

Missouri WIC Program
Funding Analysis
Final Report

Submitted To:

The Missouri Department of
Health and Senior Services

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By
Burger, Carroll & Associates, Inc.



www.burgercarroll.com

1421 Luisa Street, Suite A
Santa Fe, Nm 87505
Office # (505) 982-9880
Fax # (505) 982-9820

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I. INTRODUCTION AND EXECUTIVE SUMMARY

I.1. INTRODUCTION

This document is Deliverable Number 14, the final report for Contract Number C302059001 between Burger, Carroll & Associates, Inc. (BCA) and the Missouri Department of Health and Senior Services WIC Program. This contract is in response to RFP No. B3Z02059, issued by the Missouri Office of Administration for the purpose of conducting an analysis of WIC funding in Missouri.

This project was conducted by a team of BCA principles and staff, and two subcontractors. The core project team included:

Julie Carroll, Dr. P.H., President – Contract Executive

Dennis Bach, M.P.A., Vice-President – Project Manager

Kathy Hillock and Debra Brady – Project Analysts

This team was assisted in the conduct of Local WIC Contractor site visits by several other BCA staff including Dave Mikelson, Doug Burger, Maria Romero, and Lyn VanRaden. Two Missouri-based subcontractors assisted BCA on this project, Charles Buchanan, CPA, PC, and Sinclair Solutions.

This project was conducted between the months of April and July 2002. BCA would like to acknowledge the assistance and contributions of Missouri State WIC staff in the Department of Health and Senior Services offices in Jefferson City. In particular, Victoria Fehrmann Warren, Bureau Chief for Nutrition Services and WIC, and Diana Love, Associate Bureau Chief and project manager, provided extensive assistance by answering numerous questions, providing reports, electronic files, and other resource materials, and by reviewing draft work products throughout the project.

One of the largest tasks within this project was conducting site visits to thirty Local WIC Contractor administrative offices and an equal number of clinics. This task required substantial coordination between BCA and Local WIC Contractor staff to develop a workable schedule; hours of Local WIC Contractor staff time (by both WIC staff and Local Contractor administrators) for interviews; and the collection and copying of substantial amounts of documentation, all within a very compressed period of time. Without exception, the Local WIC Contractor staff were cooperative, helpful, and insightful. The project could not have been completed without their assistance and their positive attitude towards the project. It is a reflection of the historic dedication of WIC staff to going “above and beyond” to achieve their mission.

I.2. ALTERNATIVE FUNDS ALLOCATION METHODOLOGIES

One of the primary requirements of this project was to develop a minimum of three alternative funds allocation methodologies for use with Local Contractors. For purposes of comparison,

Section II.2 describes the current funds allocation methodologies. Four alternatives (I-IV) are summarized below, and explained in further detail in Section V.7, V.8, V.9 and V.10 of the report, respectively. These sections provide the details, rationale, costs, benefits, and limitations of each approach. Although we believe any of the four alternatives could work well for Missouri, we hesitate to describe any single one of them as BCA's recommendation. These alternatives should first be presented to and discussed with the Local Contractors that are responsible for local program administration. The Missouri Department of Health and Senior Services may find it useful to consider their input before deciding which of these alternate strategies to implement. The Department may also decide to make minor modifications to any of these strategies before implementing it based on this input.

I.2.1. Alternative One

The first alternative is based on providing an administrative grant per participant. This is the funds allocation methodology most commonly used in other states and in the national funding formula. The most common variable used within this approach is based on the concept that there are economies of scale in the operation of a Local WIC Contractor. It presumes that larger Local Contractors can distribute their overhead cost over more participants, possibly even more programs, and thus the administrative cost per person should be lower.

The first alternative proposal follows this approach. Missouri would first determine the amount of funds available for Local Contractor contracts and then calculate the average administrative grant per participant using the total caseload to be allocated. Next it would rank all of the Local Contractors by their assigned, authorized caseload, from largest to smallest. Local Contractors would then be divided into five groups or "bands." The amount of administrative funds per participant for each band would be adjusted up or down from the statewide average, with the highest amount in the band with the smallest Contractors, and the lowest amount in the band with the largest Local Contractors. The base administrative grant for each Local WIC Contractor would equal the rate for its band times the authorized caseload. The state would also continue to provide special project grants in addition to the base grant level. As described in Section V.1.1 of the report, these special project grants would be designed as incentives to promote improved performance.

I.2.2. Alternative Two

The second alternative is also based on a grant per participant concept, but is a more elaborate methodology which attempts to take into account more of the variables that affect cost.

The first step in this approach is to define the base rate, which is the average administrative grant per person available under the current year's funding. Factors are identified that affect cost, such as size of authorized caseload, salary differentials, number of clinic sites, ratio of certifications to participation, and travel requirements. For each of these individual factors, all Contractors are ranked, from highest to lowest (or largest to smallest). Contractors that rank above the statewide mean on a factor receive a positive adjustment in the base rate; Contractors below the statewide mean receive a negative adjustment for that factor. Any particular Local WIC Contractor may receive both positive and negative adjustments on various factors. For

each Local WIC Contractor, the final adjusted base rate is multiplied times the authorized caseload to determine the contract amount.

I.2.3. Alternative Three

Alternative three is a hybrid of the first two. It uses the same bands as the first two alternatives to account for the economies of scale available to larger agencies. It also uses one, and only one, of the adjustment factors found in alternative two, a salary differential. Personnel costs typically account for eighty to ninety percent of the total cost of local operations. Regional differences in the cost of hiring professional staff have a significant impact on Contractors' budgets and are therefore recognized in the funding methodology. Of all the factors identified for alternative two, salary differentials are the most defensible. The other factors in alternative two have some financial impact as well. However, these impacts are not nearly as significant as differences in personnel cost, and they are more open to debate. Alternative three avoids potentially endless second-guessing about the relative effect of the other factors, how much weight they should have in the methodology, and whether they are the only factors that should be included.

I.2.4. Alternative Four

Alternative four is based on the recognition that funding formulas are unable to take into account special circumstances of a Local WIC Contractor. It uses a base grant per participant, but relies equally on the professional judgment of state agency review staff. Final contract amounts are negotiated between state and local staff.

In this alternative, Missouri would first determine the amount available for Local Contractors. It would then calculate a statewide base administrative grant per participant that would use ninety percent of this amount. This grant per participant is then multiplied times each WIC Contractor's assigned, authorized caseload to provide the target funding level. These target levels are provided to Contractors. Contractors may submit a budget for an amount above or below the target; however, any increases above the benchmark must be justified in the Local WIC Contractor Plan. The remaining ten percent of the available Local Contractor funds are held in reserve to cover requests above the target levels. If the state agency review staff do not agree with the justifications, or if insufficient funds are available to honor all increases, state and local staff will negotiate a final budget amount.

It is assumed that most Contractors would request more, rather than less, funds, and that the total requested would equal more than the total of the target levels. Contractors could request funds for special projects or initiatives, but would first have to show that all basic program requirements are met.

I.2.5. Options and Other Recommendations

Section V of this report provides additional options within each of these alternatives, along with recommendations that cross all of the alternatives. These recommendations have to do with enhanced processes for budgeting funds to provide the maximum amount possible to

Local Contractors, continuing to pay for some activities outside of the core funding methodology, and the state agency continuing to purchase some items directly and providing them to Local Contractors to use.

I.3. THE NATURE OF WIC FUNDS ALLOCATION

Any one of the alternatives described above would provide an acceptable method for allocating funds to Local WIC Contractors in Missouri. It is difficult, if not impossible, to state unequivocally that any one alternative is better than the others. A key step in implementing any new funding methodology is to provide an opportunity for the Contractors who will be affected by it to have input into the planning process before the Department makes its decision. Contractors are more likely to accept the equitableness of the methodology if they have some involvement in the decision making process. We recommend that Missouri WIC provide a forum for interested Local WIC Contractor and administrative staff to review the findings from this report and meet with the State office over the next several months to share their ideas regarding the revised funds allocation methodology. This invitation should be extended to the current group of Contractors, but as part of the Department's strategy for developing a new procurement process, it may also want to invite prospective new Local Contractors to participate in this process.

Nationally, the WIC Program has been fortunate in that appropriation levels have historically tended to increase over the years. However, administrative requirements have increased along with caseloads, so that it sometimes appears that administrative funding levels have not kept up with demands. State WIC Programs also work with a finite amount of funding each year. Consequently, when a state decides to change its process for allocating funds to Local Contractors, increases to some Contractors typically come at the expense of other Contractors.

The Missouri WIC Program appears to be in a relatively good position to implement changes in its funds allocation methodology. The analysis described in this report shows that by ensuring that all funds are properly allocated between the state and Local Contractors, Missouri should be able to provide additional funds to many, if not most Local Contractors, and minimize the reductions to other Contractors, even while changing the allocation process. Budgeting and allocating federal WIC funds is a difficult task for state agencies, as the initial funding levels are often not known until after the start of the federal fiscal year, and the funding levels are subject to change during the year as a result of reallocations. It is important for any new funding methodology to have a mechanism to allocate additional funds that may become available mid-year to Local Contractors to ensure optimum grant utilization. By efficiently budgeting all available funds, Missouri can provide increases to some Contractors through a new allocation process without having to reduce contract amounts as much for other Contractors.

I.4. PROCUREMENT OF LOCAL WIC CONTRACTORS IN MISSOURI

Missouri currently has 119 independent Local WIC Contractors, the most of any state WIC Program in the country. This is because, with a few exceptions, there is a separate Contractor

in each county. In addition, some urban counties have multiple Contractors. As part of this study, BCA examined the feasibility of consolidating these contracts, so that Missouri would have fewer, larger Contractors covering larger geographic service areas.

BCA has concluded that it is possible for Missouri to begin moving in this direction; however, a wholesale shift to regional contracts over the next two years will require both careful planning and an immediate start. For reasons explained in this report, adopting this approach on a large scale would probably require identifying a number of alternate Local Contractors as well as changing the relationship with some current contractors. While there are some obvious possibilities, such as the networks of Federally Qualified Health Centers (FQHCs) and Community Action Agencies (CAAs), much work needs to be done to identify the potential level of interest on their part and to “market” the idea of applying for WIC contracts. The Department needs to define potential regional service areas and ensure that there would be enough Contractors to ensure statewide coverage.

One possible initial step in this process is to issue a Request for Information (RFI) prior to developing a Request for Proposals (RFP). An RFI is a vehicle for obtaining needed information about the potential pool of Contractors without committing the Department to a particular course of action.

This report discusses funds allocation methodologies and procurement processes separately. However, it should be understood that the two issues are intertwined. For example, in recognition of the fact that smaller agencies do not operate as cost effectively as larger agencies, all of the revised allocation methodologies would shift a greater proportion of funds to smaller agencies. The Department desires to minimize the shift of resources from more efficient to less efficient agencies by moving to larger, regional agencies. Some of the allocation methodologies use factors that are affected by the size and geographic service area of the Contractors. Some methodologies are easier to implement with a stable base of Contractors than with a large unknown group of Contractors. These issues are discussed in Section V, which explains the proposed alternatives in detail.

II. BACKGROUND AND PURPOSE OF PROJECT

II.1. PURPOSE AND GOALS OF THE PROJECT

The overall purpose of this project as described in the Request for Proposals was to “...conduct a detailed analysis of the current Missouri WIC operations and provide a minimum of three (3) alternative approach recommendations for Missouri Local WIC Contractor funding and contracting.” In addition, BCA was asked to provide recommendations regarding the procurement process for contracting with Local Contractors. To begin this analysis, it was first necessary to understand the basic approach to allocating funds for Local Contractors in Missouri. Salient aspects of the current approach are described below.

II.2. CURRENT METHODOLOGY FOR FUNDS ALLOCATION

The funding methodology for Local Contractors consists of a base allocation, funding for special projects and direct purchases by the State for items to be used by Local Contractors. Each of these three components is discussed below.

II.2.1. Basic Allocation/Reallocation Process

The current Local Contractor funding methodology has been in place in Missouri, with minor modifications, for approximately thirteen years. The primary underlying principle of the base allocation is the use of an “administrative grant per participant,” based on the authorized caseload level.

Local WIC contracts are awarded on a federal fiscal year basis, to match the period in which the federal WIC Program funds are allocated to the states. Approximately nine months into a contract period, the Department begins the budgeting process for the following contract period. The Department estimates the amount of federal funding it will receive the following year and from that estimates the overall monthly caseload size the federal food funds will support. The Department also looks at the current level of participation, recent participation trends (increasing or decreasing), and the anticipated end of the year participation. From that information a starting statewide caseload figure and individual caseload targets are established for each Contractor.

Staff from DHSS District offices provide advice and assistance as requested by Local WIC Contractors as they develop their Local Agency Plan (LAP) for the coming contract period. The plans include, among other information, their individual caseload targets and a budget. The budget is based on the current year’s administrative grant per participant times their monthly caseload target. For fiscal years 1999 through 2002, the administrative grant per person was \$7.75. The same figure is used for all Contractors. This grant per person amount was intended to provide approximately \$12.5 million for local WIC contracts, although the actual amount has been slightly under that some years because some Contractors did not accept the full caseload level they were offered. During the year, each Local Contractor can invoice the Department for the lesser of their actual expenses, or their total contract amount. If a

Contractor's actual reported expenses exceed the annual contract amount, the invoice will be reduced, or not paid at all.

During the year, the State Agency (SA) monitors the number of participants served by each Local Contractor. Contractors that are serving two percent less than the number authorized may have their authorization, and their contract total, reduced. Conversely, Contractors that serve more than their authorization may request an increase in authorization levels, provided that sufficient food funds are available. In this event, they can also receive an increase in administrative funding. For Contractors whose budgets are increased or decreased due to changes in caseload authorization, the change is not based on the original \$7.75 amount. Instead, it is based on a calculated "personnel cost per participant," using the personnel cost from that Contractor's budget and the additional caseload authorization. The concept behind this is that most other costs are fixed, and that the primary variable is the amount of staff time required to serve the additional participants. Any adjustments to Local Contractor grants are made at the end of each quarter.

II.2.2. Funding for Special Projects

The vast majority of Contractor funds are allocated on the grant per participant methodology described above. Additional contract funds are available to all agencies that apply for them to be used for training and breastfeeding peer counselor programs. Any remaining funds are awarded on a competitive basis as special grants. Contractors apply for special grant funds and describe the specific project they intend to do. Some of these past projects have been for breastfeeding promotion, improved clinic management, and outreach initiatives.

To put the breastfeeding peer counselor funding in context, the total funds allocated for this purpose are less than \$200,000 (compared to the \$12.5 million allocated through the base grants). For those Contractors that apply, the training funds will cover the entire cost of attendance at the bi-annual statewide WIC conference and the total cost (hotels, per diem, mileage, salary) of sending employees to training provided by the Department. (Currently, the Department pays costs such as per diem and mileage directly to the employee. Hotel bills are charged directly to the Department. Contractors can choose to request funds to pay the associated salary costs, or pay for this out of their base grant.)

The SA has established rules regarding the use of budgeted funds. For example, a Contractor can shift funds between cost categories in their budget by up to ten percent without having to formally amend their budget. Likewise, they can apply some of their base grant funds to the cost of a special grant initiative. However, they cannot use special grant funds to cover costs budgeted for their base grant, without prior approval from the SA.

II.2.3. Direct Purchases for Local WIC Contractor Use

In addition to the funds provided to Local Contractors through their base grant and special grants, the SA purchases some items directly that are intended for Contractor use. This includes most of the computers and printers used in clinics and offices, microcuvettes used for drawing blood in clinics for eligibility determination, the calendars with nutrition messages

provided to participants, nutrition education materials, and printed forms. As described in Section III.7 centrally purchasing items for Local Contractors is a common practice among states. Many states find this to be an administratively efficient and cost effective practice.

To put these purchases in context, in FFY'1999, the total amount equaled \$950,008, of which \$677,008 was for the purchase of new or replacement computer hardware, and the remaining \$273,000 was for the other routine purchases for clinic and participant use, as described above. These routine purchases equaled \$318,000 in FFY'2000 and \$363,000 in FFY'2001. In FFY'2001, there was another large hardware purchase, bringing the total that year to \$858,531.

In summary, of approximately \$12.6-\$13.2 million directly benefiting local agencies, 90-96% has been provided through the base per participant allocation, 2-7% were through direct purchases, and 2-3% were through special grants.

II.3. LIMITATIONS OF CURRENT METHODOLOGY

The current funds allocation methodology has been used in the Missouri WIC Program for more than a decade. The state has made minor modifications to this approach to address needs and issues that have arisen during this time. However, the State has received complaints from Contractors about the general inadequacy and the distribution of funding in recent years. Some shortcomings that prompted the Department to undertake this study are as follows:

- The use of a single grant per participant amount for all Contractors does not take into account any inherent, unavoidable differences in cost of operation between Contractors.
- The policy of providing additional funds for items such as breastfeeding peer counselors and for training provide some benefit to Contractors who could not cover the financial cost of these initiatives in their base grant; however, since they are available to all Local Contractors, they do not compensate for the disparities created by using the same administrative grant per person for all Contractors.
- Many Contractors maintain that the current \$7.75 amount does not cover their entire cost of providing services. Many of these Contractors report that they contribute financially to the operation of the WIC Program, by providing a variety of in-kinds services and costs.
- While many Contractors complain that the grant does not cover their basic cost of operation, some agencies are able to afford items such as out of state conferences and clinic renovations. This indicates that there is a disparity or inequity in the allocation of funds between Contractors.
- There are sanctions for Contractors that under serve their target caseload (e.g. by more than two percent). However, there are no other sanctions for Contractors that do not abide by other aspects of their LAP.
- The methodology used to identify the total amount of funds available for Local Contractor contracts and the corresponding administrative grant per participant does not ensure that all available funds are allocated to the local level.

III. DESCRIPTION OF PROJECT TASKS AND ACTIVITIES

Four main sets of tasks were completed in this project to provide the information necessary to develop the recommendations. These included:

- Meetings and interviews with state agency officials in the Department of Health and Senior Services;
- Compilation, review, and analysis of financial and program data available from the State WIC office;
- On-site visits to thirty Local WIC Contractors across the State and interviews with management and program staff; and,
- A national survey and telephone interviews with other state WIC programs to determine how other states addressed the issues raised in Missouri. Each of these sets of tasks is described in the following sections.

III.1. INTERVIEWS WITH MISSOURI STATE AGENCY OFFICIALS

BCA project staff made a total of three trips to Jefferson City, Missouri to meet with program and department staff and to collect information for the project.

III.1.1. Project Initiation Visit

The project initiation meeting was held on April 10th through April 12th. BCA project staff reviewed the project goals and timeline with Missouri WIC and DHSS officials. Staff were interviewed on a number of topics, including the history of WIC service delivery in Missouri, the current funding allocation process, the Local WIC Contractor Plans, the overall composition of the current Local Contractors, the state agency budgeting process, and related initiatives in Missouri state government that could affect WIC's Local WIC Contractor procurement process. BCA also met with staff from the Department's Bureau of Grants and Contracts, the Department's Internal Auditor's Office, and the Center for Local Public Health Services.

Also during the initiation visit, BCA staff collected and briefly reviewed data made available by state WIC staff. This data is described in Section III.2 below.

The initiation visit was important to the project primarily for BCA's understanding of the issues that led to this project and for further refining the state agency's priorities for the project.

III.1.2. First Follow Up Visit

The first follow up visit was conducted on May 29th and 30th. The purpose was to provide a status report on the project to date, conduct additional interviews, and answer questions

regarding BCA's analysis of the data. The status report included a briefing on the results of the initial Local Contractor visits.

The first follow up visit served as a milestone to confirm that the information being collected in the Local Contractor visits met the state's expectations. It also provided an opportunity to identify additional sources of data that needed to be captured and analyzed in order to provide a complete picture of Local Contractor costs. As a result of this visit, it was decided to shift some project resources to capturing detailed information on in-kind costs from the WIC administrative cost reports (WIC-24) on file in the state office. One BCA project team member made an additional unplanned trip to Jefferson City and gathered the reported monthly in-kind personnel and other costs from all Local Contractors for the thirty-six months in the three-year study period.

III.1.3. Second Follow Up Visit

The second follow up visit was conducted on July 10th and 11th. This visit included a briefing on the remaining Local Contractor visits, and a summary of the findings from the state agency interviews that were conducted to date. BCA also shared draft copies of the preliminary compilations of the data under analysis.

The second follow up visit was important primarily as the first opportunity to share ideas gathered from interviewing state WIC directors in other states around the country. At the time of this visit, nine interviews had been completed. BCA intended to use the briefing on, and discussion of, these interviews to identify any boundaries or limits to the type of recommendations the state agency would consider in this report. It was determined that state staff were open to considering the full range of possibilities that could be identified and defended.

III.2. REVIEW AND ANALYSIS OF EXISTING DATA

III.2.1. Summary of Materials Reviewed

BCA obtained copies of and reviewed an extensive variety of materials made available by the SA as part of this project. The materials, in both paper and electronic formats, included information on areas such as state agency and Local WIC Contractor organizational structures, administrative costs (from both grant funds and in-kind), participation, Local Contractor budgets and annual plans, monitoring of Local Contractors, and policies and procedures.

In addition to the list of materials which BCA received copies of, the state agency made available the entire set of monthly administrative cost reports (WIC-24) for FFYs 1999, 2000, and 2001. The reported in-kind costs from these reports were entered into an electronic spreadsheet by BCA.

III.2.2. Purpose

There were several reasons for collecting and analyzing detailed information on state and Local Contractor budgets and spending, including:

- Assessing the overall effectiveness of the state level budgeting and funds allocation process;
- Examining the net effects of the funding allocation process on Local Contractor spending and costs per participant;
- Comparing budgeted in-kind contributions with reported in-kind costs; and,
- Comparing state/local level spending percentages in Missouri with other states.

III.2.3. Analysis of Federal Fiscal Years 1999-2001 Statewide Spending

Background on WIC Funding Rules

The tables on the following pages (Tables 1.1-1.6) summarize the use of the federal WIC funds that were available for federal fiscal years 1999, 2000, and 2001. In addition to the basic grant for Nutrition Services and Administration (NSA), states have the authority to convert some NSA funds to the food grant and vice versa. They can also retain a certain amount of one year's funds and use them the following year (*a.k.a.*, "spendforward"). They can also overspend their grant up to a certain amount and borrow ahead from the following year's grant (*a.k.a.*, "backspend"). WIC Programs do not charge fees to participants, but they can recoup overcharges from authorized retailers and use some of these dollars as administrative funds. On the tables these are referred to as refunds and collections. States receive a grant award from USDA early in the year, which is often amended and increased later in the year. This makes the comparison of funding and expenditures difficult. By way of illustration, following is a chronology of funding changes for FFY'2001.

Initial NSA Grant Award	\$16,166,521
January Operational Adjustment	\$1,114,000
January Reallocation	\$454,953
March Operational Adjustment	\$49,049
April Reallocation	\$211,870
July Operational Adjustment	\$133,641
July Reallocation	\$279,215
Year Ending Grant Level	\$18,409,249

The final grant level in FY'2001 was approximately 14% higher than the initial grant award. Operational Adjustment funds are specifically requested by state agencies each year, but states do not initially know whether or not they will receive the amount they request. Reallocation funds are unspent monies from previous years that states return to FNS at year-end close out. States know that there will be a reallocation process, but not whether they will be offered funds as a result or how much they will receive. Consequently, states typically base their budgets on the initial grant award and make adjustments during the year as more funds become available. The adjustments may take the form of allocations of additional funds to Local Contractors, or

large expenditures by the state agency on behalf of Local Contractors (e.g. purchases of computer hardware). If a state receives a large reallocation of funds late in the year it may be difficult use effectively.

States must also consider their participation and Food Grant spending when allocating additional NSA funds that are received. The national NSA funding formula includes a figure referred to as the “Administrative Grant per Person” (AGP) that is used in the calculation of each state’s NSA grant. At the end of the year, if a state’s actual administrative cost per person (ACP - total NSA expenditures divided by total actual participation) exceeds the AGP by more than 10%, USDA has the authority to levy a penalty against the state. This provision is intended to prevent a state from under-serving its population (and thus under spending its food grant) while still spending all of its administrative funds. In each of the three years studied, Missouri Local Contractors served less than the levels authorized, and Missouri under-spent its food grant by eight to twelve percent. As a result, in each year the administrative cost per person exceeded the AGP for the year.

Funding Analysis

For each of the three years, we calculated the net amount of NSA funds that were available to spend at the beginning of the year and at the end of the year, and compared those amounts with actual expenditures at the state and local level. For example, if the State did not use all of its funds one year, and some of those were available as spendforward funds, they were included in the following year’s beginning of the year total. Operational Adjustment and Reallocation funds were included in the end of the year total.

For the three years, Local Contractor budgets equaled 80%, 75%, and 71%, respectively, of the initial funds available. The Local Contractors’ share of the final amount of funds available for those years was 68%, 68%, and 63%. As explained more fully in section III.8, this is a somewhat lower percent than found in most states. For states interviewed for this project, the range of final grant amounts allocated to local agencies in FFY’2001 was from approximately 75% to 90%. In FFY’1999, the average of all fifty geographic states was 75.9%. It can be misleading to compare percentages between states without also examining differences in operation. However, a further look at Missouri spending patterns for those three years suggests an explanation for the difference.

The analysis shows that for the three years, total Missouri NSA spending exceeded the amount available at the start of the year by just over 2% in FFY2000 and almost 14% in FFY’1999. However, total spending compared to year-end funds available was only 97.2%, 92.1%, and 94.5%, of the total available. Most of the additional funds received during those years was retained at the Department rather than allocated to Local Contractors. This may have been related to an inability to get Local Contractors to accept additional caseload and reluctance by the Department to allocate more NSA funds without more caseload. Because of the 110% ACP/AGP provision explained above, if the Department had allocated and spent all of the NSA funds without the Local Contractors serving enough participants to spend enough of the food grant, the State could have been subject to a penalty by FNS.

For FFY'1999, Local Contractors spent 97.6% of their contracts (allocated funds) and the Department spent 96.2% of the remaining "non-allocated" funds available at the end of the year. For FFY'2000, the Local Contractors again spent 97.8% of their contracts, but the Department spent only 80.3% of the remaining "non-allocated" year-end funds. In FFY'2001, the Local Contractors increased their spending percentage slightly to 98%. The Department spent 85.8% of the remaining year-end amount, more than the previous year but down substantially from two years prior. This was in spite of the large computer hardware purchases made by the Department for the benefit of the Local Contractors.

In FFY'1999, the amount left unspent was within the limits of what Missouri was allowed to spend forward, so all of it was available to use the following year. For the following two years, the amount unspent was more than the spend forward authority, and Missouri returned funds to USDA. In FFY'2000, the amount returned was \$250,501 (or 1.4% of the total NSA funds available at the end of the year), and in FFY'2001 it was \$570,531 (or 3% of the total NSA funds available at the end of the year).

Funding Summary Tables and Explanation

Following is a line-by-line explanation of the funding summary tables on the following pages:

NSA Grant and Spending

1. This is the amount of the Nutrition Services and Administration (NSA) Grant at the beginning of the year.
2. Operation Adjustment (OA, formerly Discretionary) funds are requested by states for specific purposes. States submit their request in late summer/early fall, but usually do not find out how much they will receive until at least January. In FFY'2001, Missouri received their OA funds in three installments (January, March, and July)
3. Reallocations are funds from the previous fiscal year that have been recovered by FNS and redistributed to states for use in the current year. The first reallocations usually do not occur until at least January, and they may be available later as well. In FFY'2001, Missouri received funds through three reallocations (January, April, and July)
4. This is the amount of the grant as of the end of the federal fiscal year, including OA and reallocation funds.
5. This is the amount of unspent funds from the previous year that Missouri is allowed to keep and use in the current year. They are available for use from the beginning of the year.
6. These are funds received back from Retailers that are used to offset program administrative expenses.
7. Conversion from Food to NSA. Under certain rules, states are allowed to move or "convert" some of the money from their food grant to their NSA grant. Since the conversion is based on participation, the certainty of these funds is not known until the end of the year. Consequently, they are not available for allocation.

8. This is the total amount of funds that were available for allocation in local contracts and for state agency level expenses, at the beginning of the year (Column D) and at the end of the year (Column F). Column G shows the percentage increase from the beginning to the end of the year.
9. This is the total of the funds put into Local Contractors' contracts at the beginning of the year (column D), the additional funds that were allocated (column E) and the final total of the contracts (Column F). These figures include any funds for special projects as well as the base grants. Column G shows the percentage increase from the beginning to the end of the year.
10. This is the percentage of the total funds available at the beginning and end of the year that was allocated to local contracts.
11. This is the difference between the total amount of NSA funds available and the amount allocated to local contracts at the beginning and end of the year (Columns D and F). Column E is the amount of the NSA increase during the year that was not allocated to local contracts. These are the funds used by the Department for state level operations.
12. This is the percentage of the total funds available at the beginning and end of the year that was not allocated to local contracts.
13. The amount in Column C is the total spent by all Local Contractors for both base grants and special projects.
14. These are the percentages of the initial contract amounts and the final contract amounts that were spent by Contractors.
15. These are the percentages that the amount spent by Local Contractors represented of the total amount of NSA funds that were available at the beginning and end of the year.
16. This is the amount that the Department spent on state level costs. It includes funds that were spent for items directly provided to Local Contractors, such as computer hardware, lab supplies, and training costs.
17. This is the percent of the initial and final amounts available to the Department for state level expenses that the Department actually spent. Note that the beginning of the year figure (Column D) is greater than 100%. This simply shows that the department spent some of the additional funds that became available during the year.
18. This is the percentage that the amount spent by the Department represented of the total amount of NSA funds that were available at the beginning and end of the year.
19. This is the total amount spent by the Department and all the Contractors.
20. Column D shows how much total NSA spending exceeded the initial amount available. Column F shows how much of the final amount available was unspent.
21. Column D shows the percentage that total NSA spending exceeded the initial amount available. Column F shows how much of the final amount available was unspent.

22. The three items labeled Post End of Year Adjustments are identified as part of the close out process that occurs approximately three to four months after the end of the federal fiscal year.
23. This is the amount of funds converted from the Food Grant to the NSA Grant. It is the same figure shown in line 7.
24. This is the amount of unspent funds that the Department is allowed to retain and use in the following year, referred to as "spendforward"). By USDA rules, these are considered the first funds expended in the following year.
25. This is the amount of unspent funds, if any, which exceed the amount of spendforward authority and are returned to USDA for reallocation the following year.

Food Grant, Spending, and Caseload Pages

26. This is the amount of the Initial Food Grant
27. This is the amount of additional Food funds received during the year. For FFY'2001 it is the net amount of a penalty, waiver of part of the penalty, and reallocation.
28. This is the amount of the Food Grant as of the end of the fiscal year, before any year-end adjustments are made.
29. This is the percentage increase in the Food Grant from the beginning to the end of the year.
30. This is the total amount of the food grant that was spent.
31. This is the difference between the ending food grant and the amount that was spent.
32. This is the percentage that the amount spent represented of the initial and final amounts available.
33. This is the amount of the Food Grant converted to NSA. It is the same amount as shown in line 7.
34. This is the amount of food funds unspent after the conversion.
35. This is the total of the local Contractors' authorized caseload at the beginning of the year (Column D) and at the end of the year (Column F). Column E is the amount of increase or decrease in authorized levels during the year.
36. This is the percentage difference between the beginning and ending caseload.
37. This is the actual statewide participation for the entire year.
38. This is the percentage of the initial and ending authorized caseloads that the actual participation represented.
39. The national NSA funding formula includes a calculated Administrative Grant Per Person (AGP), which is multiplied times a projected caseload amount to determine the amount of NSA funding a state receives. Column D shows that figure.
40. The figure in Column F is the total NSA cost (Line 19, Column C) divided by the actual participation (Line 37, Column C) to produce the actual NSA cost per person.
41. This is the percentage of the Missouri AGP that the actual Cost Per Person represents. If a State's Cost per Person exceeds the AGP by more than 10%, USDA has the authority to levy a penalty against the state. This is intended to prevent states from greatly under-serving their population (and thus not spending their food grant) while still spending all of the administrative funds.

Table 1.1
Federal Fiscal Year 1999 NSA Grant and Spending

Line #	Description	C NSA Funds Spent	D Initial Amount Available	E Total Funds Available		G % Ending of Initial
				F Mid-Year Adjustments	F Ending Amount Available	
1	Initial NSA Grant		\$15,027,129			
2	Operational Adjustment Funds			\$1,089,525		
3	Reallocations			\$1,288,485		
4	Final NSA Grant				\$17,405,139	
5	Spendforward from Previous Year		\$308,804		\$308,804	
6	Refunds and Collections				\$4,177	
7	Conversion From Food to NSA*				\$243,489	
8	Total Available		\$15,335,933	\$2,378,010	\$17,961,609	117.1%
9	Contractors' Total Contracts		\$12,197,762	\$68,757	\$12,266,519	100.6%
10	% of Total Allocated to Contractors		79.5%		68.3%	
11	Amount Available for Department Use		\$3,138,171	\$2,556,919	\$5,695,090	181.5%
12	% of Total Available for Department		20.5%		31.7%	
13	Contractor NSA Spent	\$11,966,408				
14	Contractor Spent as % Of Contracts		98.1%		97.6%	
15	Contractor Spent as % of Total NSA		78.0%		66.6%	
16	Department NSA Spent (Includes \$950,008 Spent for Contractors)	\$5,487,667				
17	Department Spent as % of Available		174.9%		96.4%	
18	Department Spent as % of Total NSA		35.8%		30.6%	
19	Total NSA Spent	\$17,454,075				
20	Total Unspent		(\$2,118,142)		\$507,534	
21	% NSA Spent of Total Available		113.8%		97.2%	
22	Post End of Year Adjustments					
23	Conversion From Food to NSA*				\$243,489	
24	Spendforward to FFY'2000				\$751,023	
25	Unspent, Returned to USDA				N.A.	

* Conversion funds not available until the end of the year.

Table 1.2
Federal Fiscal Year 1999 Food Grant, Spending, and Caseload

A	B	C	D	E	F	G
Line #	Description	Total Funds Available				
		Food Funds Spent	Initial Amount Available	Mid-Year Adjustments	Ending Amount Available	% Ending of Initial
26	Food Grant		\$50,509,931			
27	Reallocation			\$583,052		
28	Total Food Funds Available				\$51,092,983	
29	Final Available as % of Initial Available					101.2%
30	Food Funds Spent	\$45,343,244				
31	Food Grant Balance (unspent)				\$5,749,739	
32	Spending as % of Initial and Final Amount Available		89.8%		88.7%	
33	Post End of Year Conversion To NSA				(\$243,489)	
34	Food Grant Balance After Conversion				\$5,506,250	
	Description	Actual Participation	Initial Authorized Caseload	Initial AGP/ACP	Ending Authorized Caseload	Percent Ending Caseload of Initial
35	Total Authorized Caseload		1,573,908		1,554,864	
36	Final caseload as % Initial					98.8%
37	Actual Participation	1,519,908				
38	Actual Participation as % of Authorized		96.6%		97.8%	
39	Administrative Grant Per Person (AGP) From National Formula			\$10.17		
40	Actual NSA Cost Per Participant			\$11.48		
41	Percent Actual Cost of AGP					112.9%

Table 1.3
Federal Fiscal Year 2000 NSA Grant and Spending

A	B	C	D	E	F	G
Line #	Description		Total Funds Available			
		NSA Funds Spent	Initial Amount Available	Mid-Year Adjustments	Ending Amount Available	% Ending of Initial
1	Initial NSA Grant		\$15,834,629			
2	Operational Adjustment Funds			\$784,000		
3	Reallocations			\$722,290		
4	Final NSA Grant				\$17,340,919	
5	Spendforward from Previous Year		\$507,534		\$507,534	
6	Refunds and Collections				\$1,538	
7	Conversion From Food to NSA*				\$ 264,647	
8	Total Available		\$16,342,163	\$1,506,290	\$18,114,638	110.8%
9	Contractors' Total Contracts		\$12,248,942	\$10,713	\$12,259,655	100.1%
10	% of Total Allocated to Contractors		75.0%		67.7%	
11	Amount Available for Department Use		\$4,093,221	\$1,761,762	\$5,854,983	143.0%
12	% of Total Available for Department		25.0%		32.3%	
13	Contractor NSA Spent	\$11,988,832				
14	Contractor Spent as % Of Contracts		97.9%		97.8%	
15	Contractor Spent as % of Total NSA		73.4%		66.2%	
16	Department NSA Spent (\$318,000 Spent for Contractors)	\$4,699,757				
17	Department Spent as % of Available		114.8%		80.3%	
18	Department Spent as % of Total NSA		28.8%		25.9%	
19	Total NSA Spent	\$16,688,589				
20	Total Unspent		(\$346,426)		\$1,426,049	
21	% NSA Spent of Total Available		102.1%		92.1%	
22	Post End of Year Adjustments					
23	Conversion From Food to NSA*				\$264,647	
24	Spendforward to FFY'2001				\$668,014	
25	Unspent, Returned to USDA				\$250,501	

* Conversion funds not available until the end of the year.

Table 1.4
Federal Fiscal Year 2000 Food Grant, Spending, and Caseload

A	B	C	D	E	F	G
Line #	Description	Food Funds Spent	Total Funds Available			% Ending of Initial
			Initial Amount Available	Mid-Year Adjustments	Ending Amount Available	
26	Food Grant		\$50,941,199			
27	Penalty			-\$1,480,765		
28	Total Food Funds Available				\$49,460,434	
29	Final Available as % of Initial Available					97.1%
30	Food Funds Spent	\$44,664,168				
31	Food Grant Balance (unspent)				\$4,796,266	
32	Spending as % of Initial and Final Amount Available		87.7%		90.3%	
33	Post End of Year Conversion To NSA				(\$264,647)	
34	Food Grant Balance After Conversion				\$4,531,619	
	Description	Actual Participation	Initial Authorized Caseload	Initial AGP/ACP	Ending Authorized Caseload	Percent Ending Caseload of Initial
35	Total Authorized Caseload		1,580,400		1,527,313	
36	Final caseload as % Initial					96.6%
37	Actual Participation	1,484,580				
38	Actual Participation as % of Authorized		93.9%		97.2%	
39	Administrative Grant Per Person (AGP) From National Formula			\$10.79		
40	Actual NSA Cost Per Participant			\$11.24		
41	Percent Actual Cost of AGP					104.2%



Table 1.5
Federal Fiscal Year 2001 NSA Grant and Spending

A	B	C	D	E	F	G
Line #	Description	NSA Funds Spent	Total Funds Available			% Ending of Initial
			Initial Amount Available	Mid-Year Adjustments	Ending Amount Available	
1	Initial NSA Grant		\$16,166,521			
2	Operational Adjustment Funds			\$1,296,690		
3	Reallocations			\$946,038		
4	Final NSA Grant				\$18,409,249	
5	Spendforward from Previous Year		\$668,014		\$668,014	
6	Vendor Collections Converted to NSA				\$188,581	
7	Conversion From Food to NSA*				\$0	
8	Total Available		\$16,834,535	\$2,242,728	\$19,265,844	114.4%
9	Contractors' Total Contracts		\$11,876,906	\$342,128	\$12,219,034	102.9%
10	% of Total Allocated to Contractors		70.6%		63.4%	
11	Amount Available for Department Use		\$4,957,629	\$2,089,181	\$7,046,810	142.1%
12	% of Total Available for Department		29.4%		36.6%	
13	Contractor NSA Spent	\$11,978,673				
14	Contractor Spent as % Of Contracts		100.9%		98.0%	
15	Contractor Spent as % of Total NSA		71.2%		62.2%	
16	Department NSA Spent (Includes \$858,531 Spent for Contractors)	\$6,045,753				
17	Department Spent as % of Available		121.9%		85.8%	
18	Department Spent as % of Total NSA		35.9%		31.4%	
19	Total NSA Spent	\$18,024,426				
20	Total Unspent		(\$1,189,891)		\$1,241,418	
21	% NSA Spent of Total Available		107.1%		93.6%	
22	Post End of Year Adjustments					
23	Conversion From Food to NSA*			\$0		
24	Spendforward to FFY'2002				\$671,258	
25	Unspent, Returned to USDA				\$570,531	

* Conversion funds not available until the end of the year.

Table 1.6
Federal Fiscal Year 2001 Food Grant, Spending, and Caseload

A	B	C	D	E	F	G
Line #	Description	Total Funds Available				
		Food Funds Spent	Initial Amount Available	Mid-Year Adjustments	Ending Amount Available	% Ending of Initial
26	Food Grant		\$48,237,304			
27	Net of Penalty, Waiver, & Reallocation			\$479,270		
28	Total Food Funds Available				\$48,716,574	
29	Final Available as % of Initial Available					101.0%
30	Food Funds Spent	\$47,727,505				
31	Food Grant Balance (unspent)				\$989,069	
32	Spending as % of Initial and Final Amount Available		98.9%		98.0%	
33	Vendor Collections Converted to NSA				(\$188,581)	
34	Post Conversion Food Grant Balance (unspent)				\$800,488	
	Description	Actual Participation	Initial Authorized Caseload	Initial AGP/ACP	Ending Authorized Caseload	Percent Ending Caseload of Initial
35	Total Authorized Caseload		1,532,504		1,517,999	
36	Final caseload as % Initial					99.1%
37	Actual Participation	1,501,722				
38	Actual Participation as % of Authorized		98.0%		98.9%	
39	Administrative Grant Per Person (AGP) From National Formula			\$11.51		
40	Actual NSA Cost Per Participant			\$12.00		
41	Percent Actual Cost of AGP					104.3%

III.2.4. Analysis of State Level/Statewide Budgeting Process

From the discussion of NSA funding in Section III.2.3 (pages 11 and 12), it should be clear that the annual budgeting process for these funds involves a degree of uncertainty and some risk. Decisions regarding how much to initially allocate to local Contractors and retain for Department operations for the following year must be made during the summer based on estimates of the level of initial funding expected from USDA. While the amount of funding generally increases each year, there is no guarantee that this will happen, and there have been years when funding has not increased.

The administrative grant per participant amount used in the current allocation process to calculate Contractor budgets was not increased during the three-year period, even though the total amount of funds available had increased each year.

In FFY'1999, the amount authorized in the final Local Contractor budgets (including special grants) divided by the final authorized caseloads equaled \$7.88. If the \$507,534 in spendforward funds had been added to the budgets, it would have provided an average of \$8.21 per participant.

In FFY'2000, the amount authorized in the final Local Contractor budgets (including special grants) divided by the final authorized caseloads again equaled \$7.88. If just the \$250,501 in funds returned to USDA had been added to the budgets, it would have provided an average of \$8.05 per participant. If those funds and the \$668,014 in spendforward funds had been included, it would have provided an average of \$8.48 per participant.

In FFY'2001, the amount authorized in the final Local Contractor budgets (including special grants) divided by the final authorized caseloads equaled \$7.86. If just the \$570,531 in funds returned to USDA had been added to the budgets, it would have provided an average of \$8.22 per participant. If those funds and the \$671,258 in spendforward funds had been included, it would have provided an average of \$8.66 per participant.

The spendforward amounts in these three years were still available following significant year-end investments in computers and software for Local Contractors. The SA could continue to be fiscally conservative by providing a reserve fund at the state level for contingencies and still have increased the grant per participant during the preceding three years.

The state agency should be able to provide additional funding to Local Contractors by increasing the administrative grant per participant rate in advance of implementing a new funding methodology. Section IV.3. describes some of the considerations in the transition from the current process to a new methodology. An interim increase in rate should be sufficient to at least cover the amount of funds that would be returned to USDA. However, the state should not allocate the total estimated amount of additional funds available in advance of implementing a new funding methodology.

III.2.5. Analysis of Local Contractor Funding and Expenditure Patterns

Expenditures of Contract Funds

The budgets for Local Contractors during FFYs 1999 through 2001 were based on a base grant per participant of \$7.75 for all Contractors. In addition to this base, Contractors were able to apply for special project grants. The tables in Appendices A-1, A-2 and A-3 provide a detailed picture of the initial and ending authorized caseloads, actual participation, contracted amounts (both base grant and special projects) and spending for each Local Contractor for each of the three years examined. Overall, Contractors were reimbursed an amount close to the final contract total, but the percent for individual Contractors varied considerably. The portion of the Contractors that were reimbursed the total amount of their contract increased steadily each year. (Some of the reasons for this are described in the following section.) Conversely, the lowest percent spent by any Contractor also declined each year (see Table 2). Absent other explanatory factors, this might suggest that there is a growing disparity in the allocation of funds compared to the need for funds.

Table 2—Percent of Total Local Contract Amount Reimbursed

	Highest Reimbursement	Number of Contractors @ 100%	Mean (average) Reimbursement	Lowest Reimbursement
FFY'1999	100%	50	97.8%	86.2%
FFY'2000	100%	59	94.6%	74.8%
FFY'2001	100%	71	98.0%	71.1%

There should be some variation between Contractors around the base \$7.75 figure, due to the special grants and other adjustments in either caseloads or budgets. Budget increases during the year to accompany caseload increases were calculated based on a lower grant per participant using Contractors' personnel costs. BCA examined the net effect on the expenditures per participant by authorized and actual participation. The following tables (Table 3 and 4) summarize the results:

Table 3—Amount of Contract Funds Reimbursed Divided by Final Authorized Caseload (Expenditures Per Authorized Participant)

	Highest % Spent By Contractors	Mean (average) % Spent	Lowest % Spent By Contractor
FFY'1999	\$8.49	\$7.73	\$6.68
FFY'2000	\$9.37	\$7.84	\$6.31
FFY'2001	\$9.67	\$7.79	\$5.66

**Table 4—Amount of Contract Funds Reimbursed Divided by Final Actual Participation
(Expenditures Per Actual Participant)**

	Highest Expenditure Per Participant	Mean (average) Expenditure Per Participant	Lowest Expenditure Per Participant
FFY'1999	\$9.25	\$7.90	\$6.92
FFY'2000	\$9.80	\$8.12	\$6.89
FFY'2001	\$10.00	\$7.92	\$5.70

Local contractors consistently have spent more per actual participant than initially budgeted, primarily because they have served fewer participants than authorized.

Budgeted and Reported In-Kind Contributions

The other piece of the spending picture is the in-kind contributions by Local Contractors. In preparing the budgets for the Local Contractor Plan each year, Contractors are asked to estimate the amount of in-kind costs they will incur. As Contractors submit their monthly WIC-24, Administrative Cost Reports, they report the amount of in-kind incurred for the month. There is a specific line to report in-kind personnel costs. Other in-kind costs are sometimes noted in the comment section of the report.

There is also a third source for identifying Local Contractors' in-kind contributions. If a Local Contractor submits a WIC-24 report and the costs charged to the grant exceed the contract total for the year, the Department does not reimburse the portion of the reported costs that exceed the contract amount. These un-reimbursed funds represent actual costs that were incurred and must be covered by some other source of funds, so in fact they are an in-kind contribution. The number of Contractors with un-reimbursed funds was twenty-nine in both FFY'1999 and FFY'2000, and twenty-seven in FFY'2001. The relatively high number of Contractors who do this indicates that it is an intentional process, rather than poor accounting practices by those Contractors. In fact, during the Local Contractor visits, discussed in more detail in section III. 4., some Contractors stated that this was their chosen method of reporting the total program cost to the state. Unless stated otherwise, all references below to in-kind contributions include all three types (personnel, other, and un-reimbursed).

The state agency has frequently heard from Local Contractors that the contract funds are insufficient to cover the total cost of operation for the WIC Program. This project systematically analyzed both budgeted and reported in-kind costs for the three-year period in order to determine the overall magnitude of in-kind contributions and their relationship to any alternative funding methodology.

In FFY'1999, seventy-nine Contractors showed in-kind contributions in the budget portion of their LAP. In FFY'2000, the number decreased to sixty-four, and in FFY'2001 the number was back up

to seventy-three. For each of these years, the number of Contractors actually reporting in-kind was greater than the number that had budgeted in-kind. However, there was a less than perfect correlation between the Contractors that budgeted and those that reported in-kind. The following table (Table 5) summarizes this relationship.

Table 5—Number of Local Contractors With Budgeted and Reported In-Kind Costs

	No. With Budgeted In-Kind	No. With Budgeted & Reported In-Kind	No. with Budgeted But Not Reported In-Kind	Total No. With Reported In-Kind	No. With Reported But Not Budgeted In-Kind
FFY'1999	79	66	13	95	29
FFY'2000	64	49	15	80	31
FFY'2001	73	62	11	94	32

Table 6 illustrates the relative magnitude of each of the three types of in-kind contributions. These figures should be considered a conservative estimate for two reasons. First, a number of Contractors stated during the on-site visits that they do not bother to collect or report in-kind contributions, since they do not get reimbursed for them. Thus, the total may be understated. Further, while there is a line on the WIC-24 report for in-kind personnel, there is not a designated line for other in-kind. Some Contractors expressed a belief that this meant the SA was not interested in these costs. So, these are probably understated even more than the personnel in-kind.

Table 6—In-Kind Costs by Category and In Total, By Fiscal Year

	Un-reimbursed Costs	Personnel In-Kind Reported	Other In-Kind Reported	Total In-Kind
FFY'1999	\$322,238	\$194,459	\$ 27,841	\$ 544,537
FFY'2000	\$286,443	\$840,301	\$126,755	\$1,253,499
FFY'2001	\$397,605	\$686,509	\$170,036	\$ 990,298

To put these numbers in perspective, it is best to consider them in the context of the total program cost as described in the following section.

Total Program Costs

The total WIC Program cost is a combination of the reimbursed contract funds and the total in-kind of all three types discussed above. The following table (Table 7a) illustrates the share of total program costs coming from grant funds compared to the share provided by total in-kind contributions.

Table 7a--Percentage of Total Program Costs from Local Contract Funds and In-Kind Contributions From All Local Contractors

	Total Local Contract Funds Expended	% of Total Program Cost	Total In-Kind Contributions	% of Total Program Cost	Total Program Cost
FFY'1999	\$11,985,857	95.7%	\$ 544,537	4.3%	\$12,542,200
FFY'2000	\$11,603,616	90.3%	\$1,253,499	9.5%	\$13,215,905
FFY'2001	\$11,978,289	92.4%	\$1,254,150	9.5%	\$13,248,162

In kind contributions appear to have increased dramatically since FFY '1999 although it is difficult to know whether these changes indicate the actual costs incurred, or are a reflection of varying emphasis placed on reporting these costs.

As BCA observed that a number of Contractors do not report in-kind even if they have them, these percentages may be understated. The percent of total program costs among only those Contractors that reported in-kind are depicted the Table 7b.

Table 7b-- Total Program Costs from Contract Funds and In-Kind Contributions For Contractors That Report In-Kind Costs

	Total Contract Funds Expended	% of Total Program Cost	Total In-Kind Contributions	% of Total Program Cost	Total Program Cost
FFY'1999	\$7,749,212	93.4%	\$ 544,537	6.6%	\$8,293,749
FFY'2000	\$7,237,023	85.2%	\$1,253,499	14.8%	\$8,490,522
FFY'2001	\$8,585,026	89.7%	\$ 990,298	10.3%	\$9,575,324

It was consistent through the three years that smaller agencies reported a greater proportion of in-kind contributions than larger agencies. Table 8 shows the percentage of total program cost coming from in-kind contributions by caseload quartile (first quartile being the largest agencies) for each of the three years.

Table 8 --Percent of Total Program Cost by Caseload Quartile by FFY

Caseload Quartile	FFY'1999	FFY'2000	FFY'2001
1 st Quartile	3.4%	9.8%	8.6%
2 nd Quartile	3.1%	7.0%	9.2%
3 rd Quartile	7.4%	11.0%	12.7%
4 th Quartile	10.8%	13.4%	12.7%
All Contractors	4.3%	9.5%	9.5%

To compare the total program cost with the current level of funding, Table 9 summarizes the total program cost on a per participant basis for all Contractors.

Table 9--Total Program Cost (Contract Funds and In-Kind) Divided by Final Actual Participation

	Highest Per Participant Total Program Cost	Mean (average) Per Participant Total Program Cost	Lowest Per Participant Total Program Cost
FFY'1999	\$15.63	\$8.45	\$7.06
FFY'2000	\$16.58	\$9.12	\$6.89
FFY'2001	\$16.13	\$8.92	\$6.50

Conclusions

While it is difficult to accurately identify the actual total Local Contractor cost of the WIC Program, it is clear that the cost exceeds the federal funds made available in the last three years by several percentage points. Based on the information presented above, in-kind contributions range from approximately 5-15% of the State reimbursed amounts.

The current funding allocation process provided a base grant of \$7.75 per authorized participant, while the average actual total amount spent was \$8.92. Had a portion of the unspent funds from the last year been available to be spent locally, the reimbursement rate could have been increased to \$8.22 per participant. This would have covered about 40% of the reported in-kind costs.

III.3. LOCAL WIC CONTRACTOR SITE VISITS – DESCRIPTION

III.3.1. Purpose of Visits

The overall goal of this project was to provide recommendations for a more equitable allocation of federal Nutrition Services and Administration (NSA) funds to Local Contractors throughout the state. An essential task in this effort was to visit a representative sample of Local Contractors in order to understand their similarities and differences in operation. The directors and staff of the Contractors visited played a significant role in the project by answering questions and providing information for project staff, and by allowing project staff to observe clinic operations. The site visits, conducted using a standard protocol, provided a snapshot of the program as it exists today.

Without exception, Local WIC Contractor staff were helpful, courteous, and valuable sources of information. The project benefited greatly from the first-hand information provided by these stakeholders. As the state office considers the recommendations from this project, these Local Contractor stakeholders will continue to play an important role by considering and debating the issues and solutions presented by this project and helping achieve consensus on the future direction of Local Contractor funding in Missouri.

III.3.2. Summary of Sample Population

In selecting the sample of Local Contractors to be visited, there were many variables that needed to be considered. Missouri has considerable diversity in size of Local Contractors, from county health departments serving less than one hundred participants per month to Contractors serving over 8,000 participants. It has small rural community action agencies, with little or no related medical services and large, urban hospital based clinics. All Contractors have the same core requirements to meet, but different demands and widely divergent levels of resources with which to work.

BCA chose to visit as large a sample of Contractors as possible within the resource constraints of the project. A selection of thirty Contractors was proposed by BCA. At the project initiation meeting the list of Contractors was reviewed with state staff and confirmed. The final sample included Contractors from each district, urban and rural Contractors, and representatives of each type of Contractor the state contracts with (*i.e.*, city and county health departments, community action programs, hospitals, and private not-for-profit health clinics)

III.3.3. Schedule of Visits

BCA conducted thirty site visits to Local WIC Contractor programs during the period of late April to mid-July 2002. The Contractors visited are listed below. BCA used several two-person teams to conduct the visits. The composition of the team varied from visit to visit, partially to accommodate individual schedules, but also to provide fresh perspectives.

In the following list (Table 10), the names of BCA project team members are listed following the dates of the Contractor visits. The WIC Contractor personnel interviewed at each site included the WIC Contractor director or administrator; the WIC supervisor; other management staff as appropriate (such as a clinic manager), and the WIC Contractor fiscal officer.

Table 10—Schedule of Site Visits Completed			
Contractor	City	Visit Dates	BCA Team Members
St. Louis ConnectCare	St. Louis City	Apr 30-May 1	Dennis Bach, Charles Buchanan
Family Care Health Centers	St. Louis City	May 2-3	Dennis Bach, Harriet Sinclair
Marion County Health Dept	Hannibal	May 2-3	Dave Mikelson, Barbara Grady
Springfield-Greene County Health Department	Springfield	May 21-22	Dave Mikelson, Maria Romero
Crescent Clinic	Kansas City	May 21-22	Doug Burger, Barbara Grady
St. Luke's Hospital WIC Program	Kansas City	May 23-24	Doug Burger, Barbara Grady
Dade County Health Center	Greenfield	May 23-24	Dave Mikelson, Maria Romero
St. Louis County Health Dept.	Clayton	Jun 4-5	Dennis Bach, Harriet Sinclair
Hickory County Health Department	Hermitage	Jun 4-5	Doug Burger, Harriet Sinclair
Clay County Health Department	Liberty	Jun 4-5	Dave Mikelson, Kathy Hillock
Vernon County Health Department	Nevada	Jun 6-7	Doug Burger, Harriet Sinclair
St. Charles County Health Dept	St. Charles	Jun 6-7	Dennis Bach, Harriet Sinclair
Truman Medical Center	Lakewood	Jun 6-7	Dave Mikelson, Kathy Hillock
Tri-County Health Department	Stanberry	Jun 11-12	Dave Mikelson, Maria Romero
Dent County Health Dept	Salem	Jun 11-12	Charles Buchanan, Barbara Grady
Butler County Health Dept	Poplar Bluff	Jun 13-14	Charles Buchanan, Barbara Grady
St. Joseph/Buchanan County Health Dept	St. Joseph	Jun 13-14	Dave Mikelson, Maria Romero
Scotland County Health Dept	Memphis	Jun 18-19	Dennis Bach, Kathy Hillock
Pemiscot County Health Dept	Hayti	Jun 18-19	Charles Buchanan, Barbara Grady

Table 10—Schedule of Site Visits Completed

Contractor	City	Visit Dates	BCA Team Members
Northeast Missouri Health Council	Kirksville	Jun 20-21	Dennis Bach, Kathy Hillock
New Madrid County Health Dept	New Madrid	Jun 20-21	Charles Buchanan, Barbara Grady
Samuel Rodgers Community Health Center	Kansas City	Jun 25-26	Doug Burger
St. Louis HDC	St. Louis City	Jun 25-26	Dave Mikelson, Harriet Sinclair
Morgan County Health Dept	Versailles	Jun 25-26	Lyn VanRaden, Barbara Grady
Grace Hill Neighborhood Health Centers, Inc.	St. Louis City	Jun 27-28	Dave Mikelson, Harriet Sinclair
Kansas City Health Department	Kansas City	Jun 27-28	Doug Burger
Pettis County Health Dept	Sedalia	Jun 27-28	Lyn VanRaden, Barbara Grady
South Central Public Health Services Group, Inc.	West Plains	Jul 8-9	Barbara Grady
Howard County Health Dept	Fayette	Jul 16	Dennis Bach, Harriet Sinclair
Columbia/Boone County Health Dept	Columbia	Jul 17	Dennis Bach, Harriet Sinclair

III.3.4. Methodology

A standardized protocol was developed to insure consistency in the information obtained. A draft of this protocol was presented to members of the Division of Nutritional Health and Services - Department of Health and Senior Services at the initiation meeting. The protocol was subsequently revised and expanded to include additional guidance for the users. Training on the use of the protocol was conducted by telephone conference call on May 16, 2002, with all of the team members. The typical visit was scheduled for one and a half days, with the first day spent in the administrative office and the second half-day spent observing one or more clinic sites.

The protocol for the site visits included the following:

- WIC Contractor Executive and Staff Interviews - Information regarding Contractor mission; population served; Local Contractor Plan (how used); and, human resources structure, responsibilities and cost allocation.
- Local WIC Contractor Director or Supervisor Interviews - Management of caseload, clinics, clients; LAP; and, time studies and responsibilities for clinic tasks.

- Local WIC Contractor Fiscal Officer Interviews - Financial/purchasing management; documentation of expenses; and, reporting of cash and in-kind contributions.
- Materials Collection - Organizational charts for Contractor and WIC staff (if separate); job descriptions for each classification of WIC staff; and, WIC monthly invoices to state office for three designated months (January and August 2001, and January 2002) and time records for these months with supporting documentation.
- Clinic observation – Staff observed the overall flow of participants through a clinic, discussed job duties with clinic staff; and, accompanied participants (with their permission) through the certification process.

III.3.5. Types of Information Gathered

In addition to the interviews with key staff members identified in Section III.3.4, using the standard protocol, several documents and materials were reviewed on-site and copied. The materials reviewed included the following:

- a) WIC-24 invoices for January and August 2001, and January 2002;
- b) Supporting documentation for these invoices;
- c) Documentation of in-kind contributions for the three designated months;
- d) Review of the Contractor's cost allocation plan or federally approved indirect rate (where applicable);
- e) Review of the most recent independent audit report including any findings related to WIC; and,
- f) Review of the Medicaid Cost Report summary page that includes WIC excluded costs, if available.

The WIC-24 reports and supporting documentation were reviewed to determine if the costs charged were allowable, accurate, and documented. The records reviewed varied by site, depending on the nature of the Contractor's accounting system, but minimally included:

- Time records kept by WIC staff
- Supporting receipts and other documentation for claimed costs
- Supporting documentation for reported in-kind contributions

III.4. LOCAL WIC CONTRACTOR SITE VISITS – OBSERVATIONS AND CONCLUSIONS

III.4.1. Attitudes Regarding WIC and the Role of WIC in Contractor Mission

Local Contractor directors were asked to express their views on how the WIC Program fits into the overall structure and mission of their agency. Predictably, the placement of WIC within the organizational structure varied depending on the type of agency responding. However, across all Contractors, most directors saw the WIC Program as a valuable component of their agency and well within the scope of their mission.

In smaller Contractors, such as rural county health departments, the WIC supervisor or coordinator typically reports directly to the WIC Contractor director. In larger urban Contractors, such as hospitals or not-for-profit health clinics, the WIC supervisor may report to a clinic manager or other upper management position who in turn reports to the director. Overall, it appears that WIC Programs are fairly prominent within their agencies, and WIC supervisors have ready access to management when needed rather than being buried in bureaucracies.

Twenty-four of the thirty directors questioned offered a positive comment regarding the role WIC plays in helping them accomplish their mission. In addition to WIC, many of the Contractors offer a variety of other public health services. The majority of the Contractors view themselves as the main (if not the only) source of routine health care for the indigent population in their service area. The mission statements of city and county public health departments, in particular, speak to their commitment to creating healthier communities or maximizing wellness and healthy lifestyles. They view WIC's focus on nutrition and preventative health care as a core component of that mission.

In addition to explaining the benefits provided directly by WIC, several spoke to the fact that WIC brings people in the door where the Contractor can then provide additional services they need. The following two comments were typical of all the Contractors:

- “WIC serves the community very well. Clients frequently need other services that are offered and can be referred to them when they come in for WIC.”
- “We have a high concentration of teen pregnancy. From the WIC Program everything coordinates with our other programs, using a referral system to channel our clients throughout.”

WIC has often been described in other states and in national research studies as being an effective means of getting people into the health care system. The comments of Missouri WIC Contractor directors help confirm that role.

This is not to say that attitudes are completely positive, however. One of the two directors who offered a negative response said:

“To be perfectly honest, we’ve lost money for so long on WIC that if it were left up to me, we probably wouldn’t be doing it. Because it brings so many people in to utilize the other services we continue to struggle along.”

This comment articulates in stark fashion the downside of providing WIC services that came through in many comments. The majority of the WIC Contractor directors said that their contract WIC funds were insufficient to pay for the entire cost of the WIC Program and had to be supplemented with other funds. They justified the expenditure of additional funds because of WIC's value to their agency. However, they wished for greater WIC funding to cover more of their needs. When asked an open-ended question such as, “What do you find most challenging about managing the WIC Program in your agency,” approximately one half mentioned insufficient money in their answers. The reasons they provided for needing greater funding ranged from being able to offer staff adequate raises in salary to being able to provide the quality level of services they desired.

III.4.2. Attitudes Regarding Expansion of Service Areas or Alternate Contractors

BCA asked about Contractor's plans for future expansion of all services, including WIC. WIC Contractor directors were asked, hypothetically, would they be interested in expanding their WIC service delivery area if there were an opportunity to do so. This elicited a variety of responses.

Most directors of county health departments said they would be willing to at least consider providing WIC in a larger area. However, they also pointed out that the decision would ultimately be up to either the County Board of Health or the County Commissioners, depending on the structure of the county. Invariably, they also pointed out that WIC does not cover its total cost in its existing area, and that the funding would have to be increased to consider expansion. In other words, it is one thing for a county to supplement WIC with additional funds to serve residents of that county; it's an entirely different thing to do that to serve residents in a different county.

Some not-for-profit health clinics described a business model in which WIC was an integral part of the services delivered in their clinics. If they decided to expand their number of clinics in the future, they would naturally want to include WIC in those. However, they were not as sure about whether they would be interested in expanding WIC beyond their clinic structure; it did not fit their business model. One Contractor, after initially saying they would not be interested in expanding, made a point of coming back later to say that they would not rule it out.

One Contractor that already provides services in a multi-county area was more positive about expanding their WIC services. They have an organizational structure and mission that is not artificially constrained by county boundaries.

Conversely, none of the Contractors volunteered that they would willingly give up their WIC program in order for another Contractor to provide services in a wider area. Contractors were asked what other Contractors they were aware of that provided health services to similar populations. Contractors located in urban areas were often able to cite other service providers. In some cases they have existing referral relationships with these Contractors. In other cases, they see them as a form of competition. As might be expected, in rural areas the county health department providing WIC services is about the only game in town.

In summary, if the Department wants to convert the existing set of contracts into a reduced number of regional contracts, some portion of the existing Contractors may be interested in continuing to provide services, but other agencies will need to be recruited for some areas of the state.

III.4.3. Differences in Service Delivery Models

BCA examined the different approaches Local Contractors had developed to deliver services. A number of issues were studied to determine if there were obvious cost of service implications for these differences. Two of the primary issues are discussed below.

Integration with Other Health Services

Contractors were asked what other services, if any, are provided at the WIC clinic site, and whether these services are integrated with WIC services.

The answers depended largely on the type of Contractor asked the question. For hospitals and health clinics, WIC was typically housed in a clinic setting along with well child and prenatal care. For county health departments, which have been moving away from providing direct care for the last several years, WIC was typically the only form of health care available in that location, with a referral network to other health providers as needed. Across all Contractors there are referral networks for health services, and a variety of ancillary services available in the clinic (e.g. parenting classes, cardiovascular surveys, smoking cessation, etc.) These are typically provided by staff from other Contractors who come into WIC clinics periodically.

The degree of integration within hospitals and health clinics varies as well. In most of these, WIC is co-located, but not fully integrated. WIC and the “health clinic side” may or may not share common patient charts. WIC certifications are usually done by themselves, rather than as part of a comprehensive health exam. Separate appointment schedules are maintained. Some WIC clinics have worked hard at using heights, weights, and blood tests performed on the clinic side in lieu of taking their own measurements. Some clinics do their own heights and weights, but refer participants to an in-house lab for the blood test when needed. (The cost of the lab tests is then charged back to WIC.)

At least one Contractor has developed an extensive referral network over the years and encourages participants to bring in height, weight, and blood work done by private physicians. They have developed their own form to facilitate this process. This approach was initially developed to foster the concept of participants having a medical home, but it also reduces WIC’s cost.

The most common service available in conjunction with WIC services is immunizations. There appear to be two models. In one, a nurse doing WIC certifications screens children to determine if they are up to date and, if not, gives the needed shot(s). A more common model is found where WIC is located in a clinic setting providing other health services. In these, the child is screened by WIC, but if a shot is needed the child is sent over to the “health clinic side.” The other variation in this model is in public health agencies that provide free immunization clinics. WIC screens the child and provides an in-house referral to the immunization clinic. Lead screening is also available in some of the clinics.

In some Contractors, BCA also found referrals the other way, from health clinics into WIC for non-WIC services such as adult nutrition counseling.

While many of these variations probably have some marginal effect on the overall cost of providing services, we did not observe major increases or decreases in cost that could be attributed to their degree of integration. Most of the differences in approach were simply the result of management decisions reflecting the available resources in the Contractor. The same manager, in a different Contractor environment, might have made different decisions.

Clinic Structures and Schedules

As explained in Section III.8, which describes other states’ WIC Programs, it is quite common for Local Contractors to operate multiple clinic sites, either full or part time and either in permanent or satellite facilities. This occurs in Missouri as well. The thirty Local Contractors selected to visit for this project operate a total of ninety-eight sites. Of these, only thirty-two are full time and sixty-six

are part time. Nine Contractors did not operate any full time sites, but four of these operated more than one part time site. The other five have only one part time site. Of the twenty-one Contractors that have at least one full time site, all but seven also had multiple part time sites.

One would intuitively expect the largest Contractors (in terms of caseload) to have the most sites and the smallest Contractors the least number. Overall, among these thirty Contractors, that pattern is largely true. The largest third of the Contractors (caseloads of 1,820 to 7,970) has a total of fifty-three (53) sites; the middle third (caseloads of 840 to 1,780) has twenty-two (22) sites; and the bottom third (caseloads of 90 to 760) has twenty-three (23) sites. The second two groups are so close in number of clinics due to three Contractors in the bottom third that have seven, six, and three clinic sites, respectively. The other seven Contractors in this group have only one site, and five of these are only part time.

It appears that the number of WIC clinics a Contractor decides to operate is a function of much more than sheer caseload size, however. Other factors include the Contractor's overall structure and the need to reach special populations. For example, in some of the private health clinic Contractors the number of WIC sites is determined by the number of full service clinics the Contractor operates. Some Contractors operate very small, part time clinics in order to reach special populations that they believe would not come into other clinic settings. Two large hospital based Contractors operate two of the largest clinics encountered, with over 2,000 participants in one and 2,600 participants in the other. Yet, these two Contractors also operated part time clinics serving only 20 to 50 participants per month.

Some Contractors must transport equipment and files from their home office to each of their part time sites each month. Other Contractors have essentially permanent, part time space in which they can leave all of the furniture, equipment, and supplies when they are not there.

As explained further in the next section, Contractors staff their full and part time clinics with every conceivable combination of full and part time staff in an attempt to use their resources as efficiently as possible. Some staff are permanently assigned to one clinic, while others rotate almost daily between satellite sites.

It was beyond the scope of this project to accurately gauge the relative efficiency with which each Local Contractor utilizes their staff. However, as a general rule, it can be assumed that it is easier, more efficient, and probably more cost effective to staff a single, full time clinic site than to staff several smaller, part time sites serving the same number of participants overall. Other factors such as additional clinic rent and travel costs add to the cost of having multiple sites.

III.4.4. Differences in Uses of Staff

During the site visits information was collected as to what positions work at each clinic site and "the chain of command" at those sites. While the number of staff at a clinic, needless to say, varies by the size of the clinic all clinics had, at a minimum, a nutritionist and a clerk. Other types of positions utilized included nurses, health professional assistants (HPAs), financial officers, WIC coordinators, nutrition educators, WIC certifiers, peer breastfeeding support counselors and breastfeeding educators. About 25% of the clinics visited have a nurse on staff. About 50% use a

competent professional authority (CPA) or HPA or WIC diet technician to assist the nurse or nutritionist in the certification process. Only two sites mentioned they have on staff a breastfeeding peer counselor, although the number of Contractors with these statewide is much larger.

One additional position of note is the interpreter needed at some clinics due to the increasing number of clients who are non-English speaking. If the clinic is able to fill the role of interpreter it is typically filled either by the clerk serving the WIC clinic or “borrowed” from public health when needed. The issue of the need for more hours for an interpreter was brought up in a number of clinics as an issue.

One half of the Contractors stated that all of their WIC staff work only for the WIC Program. The other half stated that their WIC employees also have responsibilities for other programs, services, or activities in the agency. The degree of shared responsibility for these other services varies considerably. Many public health clinics operate with nurses whose only WIC responsibility is on clinic days. In other Contractors, nutritionists spend the vast majority of their time working for WIC, but also do adult nutrition counseling occasionally. In at least one Contractor, the clerical staff work on multiple programs including WIC. It appears to be more common, however, for support staff to work solely for WIC.

III.4.5. Differences in Personnel Systems and Related Issues

All of the Contractors visited have standardized job descriptions for each class of position, including minimum qualifications for a position. The majority use the minimum qualifications provided by the state WIC office. Most have established, Contractor wide or even county-wide salary ranges, although there were a couple of exceptions in which WIC employees received either more or less than the standard salary for a classification. Only one county public health Contractor reported that they do not have a standardized salary schedule. This WIC Contractor director said she can pay whatever she can get budgeted from her county commissioners. One community health center reported that they are trying to develop standardized schedules. In the meantime, they look at the market to determine how little they can offer and still be reasonably competitive.

There is substantial difference in the degree of latitude WIC Contractor managers have in awarding both starting salaries and salary increases. Large county public health Contractors often reported that annual salary increases were granted “across the board” for all county employees, and that the WIC Contractor director and WIC supervisor had little or no control over them. Their responsibility was to find the funds to pay for the increases. In other, smaller Contractors, such as community health centers, salary increases are more likely to be determined by the WIC Contractor directors or Board of Directors.

Benefit packages vary considerably between Contractors, from those who report their staff receive no benefits to a city/county health department whose benefits equal 36% of salary. The common types of benefits include health insurance, paid leave, and retirement benefits. WIC employees generally receive the same benefit packages as other WIC Contractor employees, although in some Contractors, part time employees are not eligible for benefits. In other Contractors, benefits are pro rated for part time staff. In these Contractors, WIC employees are somewhat more likely to be part time.

III.4.6. Accounting Systems and Financial Management Controls

BCA examined several related aspects of Contractors' accounting and financial management systems. As part of this task, BCA reviewed the WIC-24 monthly administrative cost report and supporting documentation for three specific months, January and August of 2001, and January, 2002. However, this review did not meet the standards of an audit, and was not intended to test the veracity of the costs reported to the State WIC Program. Instead, the purpose was to develop a general understanding of the reporting system and insure that there were established procedures that would allow for proper accounting of WIC costs.

Differences in Accounting Systems

The sophistication and complexity of the Contractor accounting systems tended to vary with the size and type of the Contractor reviewed. Quite often, completion of the WIC-24 cost report was the responsibility of the WIC supervisor or that individual's supervisor, rather than a WIC Contractor financial officer. In these situations, however, payment from the state typically went to the WIC Contractor's financial office rather than the WIC supervisor.

Overall, we found no examples of Contractors with such deficient systems that they were unable to properly account for WIC funds.

Documenting and Reporting Expenditures of Contract Funds

In every Contractor visited, the single largest category of expense was WIC staff salaries and benefits. In many Contractors, payment of WIC salaries left little or no contract funds to cover any other expenses. The most common method of recording time for both salaried and hourly workers was by completing time sheets. In a few Contractors, hourly workers used a time clock. There were as many variations of time sheets as there were Contractors. However, they all provided a way for an employee to record time to more than one activity, if their job required them to work on activities in addition to WIC.

Almost all of the other costs charged to the WIC contract were for routine program expenses such as office and medical supplies, mileage for employees, or rent for satellite clinic facilities. Documentation of these costs was typically retained in the form of receipts or purchase orders. None of the BCA project teams encountered undocumented costs for the WIC-24 Reports that were reviewed.

Evidence of Allowable Versus Unallowable Costs for Contract Funds

Virtually all of the items charged to the WIC grants for the reports reviewed were clearly allowable costs for direct program expenses, as described above. Where questions typically arise regarding the allowable costs, it is in relation to the allocation of shared costs for administration and overhead. This was not an issue in the Contractors visited primarily because in most Contractors there were not enough grant funds left over after paying direct expenses to cover any of the overhead. Instead, these costs were more often reported as in-kind contributions, if they were tracked and reported at all. Only three Contractors reported having a federally approved indirect cost rate. Two of these

Contractors do not charge this rate to the WIC contract and the third charges WIC a lower rate than their approved rate.

Attitudes and Practices Regarding Documenting and Reporting Expenditures of In-Kind Contributions

In our review of the statewide expenditure data for the three-year period, by far the largest single type of in-kind contribution was for staff salaries. This includes both un-reimbursed program staff salaries and WIC's share of administrative staff salaries. Since Contractors must have systems in place to document the time that will be charged to the WIC grant, it requires relatively little additional effort to track and report the personnel costs that are reported as in-kind contributions.

The reporting situation for other types of in-kind contributions is somewhat different. One WIC Contractor Chief Financial Officer said that he had completely revamped the Contractor's accounting system about three years earlier just so that he could track the total cost of WIC operations. He developed a cost allocation plan that identifies the WIC share of administrative overhead expense. All of these costs are reported monthly as in-kind contributions because there are no contract funds available to cover them. This Contractor, however, appears to be the exception.

Many Contractors said that it is not worth their time and effort to allocate, document, and report in-kind contributions since they do not get reimbursed for those costs anyway. A common type of non-personnel in-kind contribution is office and clinic space in facilities owned or leased by the Contractor and used for a variety of activities. While it would be possible to develop an allocation plan to document the value of the space being used by WIC, it would require a substantial amount of effort. A few Contractors expressed the belief that the state agency is not interested in knowing about in-kind costs other than salaries because of the change in format of the WIC-24 last year. While there is still a specific line to record in-kind personnel contributions, there is not a line for other in-kind contributions as before, and the space in which to write was reduced. This change was reported to be concurrent with the initiation of email submissions of the report and that at that time, the Department directed Contractors to report other in-kind in the email with which they transmitted the WIC-24. Agencies making these comments were apparently unaware of this instruction.

Other Contractors have adopted another approach to showing the state the full cost of the program. Instead of budgeting and reporting in-kind contributions each month, they simply bill all their direct expenses on the WIC-24 report. At some point during the year, their costs exceed the contract total. They continue to send in their cost reports, knowing that the state will decline to pay any amounts over the contract total. Since these are expenses that were actually incurred, the un-reimbursed expenses represent an in-kind contribution to the program.

Initially, it may seem puzzling how WIC can continue to operate, incurring expenses that are not reimbursed by the state, and not suffer cash flow problems. This is possible because WIC programs do not maintain separate cash accounts or operate on its own funds. WIC expenses are paid from some type of general account. The reimbursement from the state goes back into that fund. If expenses are disallowed, revenues from other sources make up the deficit in the fund.

More than one county public health Local Contractor director reported that the County Board of Health or the County Commissioners knew they were subsidizing WIC, but did not know to what extent. The Supervisors or Commissioners approve the WIC Contractor director's annual budget for the county health department, including an allowance for WIC. However, the amount of WIC funds is not identified separately in the budget. Some of these directors were reluctant to report their total in-kind costs because they did not want to highlight how much the county was spending on WIC.

Evidence of Allowable Versus Unallowable Costs for In-Kind Contributions

For those Local Contractors that reported in-kind personnel costs, the form of documentation was generally the same as for reimbursed contract expenses. One Contractor's director indicated that her secretary completed her monthly time sheets for her, estimating the amount of time spent on grant programs such as WIC. However, from her description of her role and typical activities, it appears that the two or three hours a month she reports as WIC in-kind is quite conservative. Still, if those hours were reported as reimbursable expenses, rather than as an in-kind contribution, they would not meet the required standard for documentation. Apart from this one example, in all of the agencies visited, the administrative staff time shown on the WIC-24 as an in-kind contribution was supported by time records. There was no evidence to suggest that the records were not a true representation of time spent.

In general, all of the in-kind contributions on the three monthly reports examined appear to have been legitimate program related expenses. They could have been shown as reimbursable expenses if there had been enough grant funds to cover them. In short, while there is evidence to suggest that the overall amount of in-kind reported to the Department is understated, we found no evidence to suggest that what is reported is not accurate or includes significant unallowable costs. Appendix B presents a summary of allowable WIC costs.

III.5. STATE AGENCY SURVEY AND INTERVIEW PROCESS

III.5.1. Survey of All Geographic State WIC Agencies

BCA first conducted an email survey of all fifty geographic state WIC Programs. The survey requested a response to a list of seventeen questions regarding the types of Local Contractors used to deliver WIC services in the state and the funds allocation process used. A copy of the survey form is shown in Appendix C. The purpose of the initial survey was to select an appropriate sample of ten to fifteen agencies with which to conduct follow up telephone interviews.

Initially, twenty-five states responded to the survey. Twenty-one of the states said that they contracted with independent Local Contractors. All but one of these said they use some type of "grant per participant" concept in their allocation methodology.

Fourteen of the twenty-one said that they use other factors to adjust their cost per participant approach. Fourteen states (not necessarily the same ones) also said that they provide additional funds for specific purposes outside of the grant per participant process. Twenty-one states said that they centrally purchase some items that are used primarily by Local Contractors. The states that

answered yes to all three of these questions were considered good candidates for telephone interviews

A follow up email was sent to fourteen of the states that did not respond to the initial request. The states that were not sent a follow up email were excluded because they were relatively small or it was known that they did not contract for services. From the follow up, eight additional surveys were received. Having met the objectives of finding states of comparable size and practices as Missouri, no further follow-up was necessary.

III.5.2. Telephone Interviews With Selected States

From the two rounds of surveys, the following twelve states were selected and telephone interviews were conducted during June and July:

California, Colorado, Indiana, Maryland, Massachusetts, Michigan, Nebraska, North Dakota, Pennsylvania, and Texas.

The interview states represent a range of sizes, from the two largest programs to one of the smallest, and several of comparable size to Missouri.

Telephone interviews were conducted with either the state WIC director or, in larger states, with other state staff designated by the director. A standard interview form, shown in Appendix D was used. In some cases, interviewees volunteered to send additional information to further explain their process. These materials included written descriptions of the process and, in two cases, actual spreadsheet files containing their funding formula. The interviews typically lasted from thirty to forty minutes.

The first part of the interview focused on the types of Local Contractors used to deliver services and the process for contracting with these agencies. The next part of the interview asked the state to describe their overall budgeting process for WIC funds. This led into the final part of the interview in which they explained their methodology for allocating funds among Local Contractors. Each of these three sections of the interview is explained below.

III.6. STATE INTERVIEWS – SUMMARY OF CONTRACTING PROCESSES

III.6.1. Numbers and Types of Local Contractors – Now and Then

Missouri has the distinction of having the largest number of local WIC agencies of any state in the country. The two largest programs, California and Texas, only have eighty-one and seventy-one Local Contractors, respectively. The other states interviewed ranged from a low of four agencies in Maryland to a high of fifty-seven in Indiana. These states get by with fewer agencies than Missouri because the majority of their agencies serve multiple counties.

States were asked whether they limit the number of agencies they contract with and how they happen to have the number of agencies that they do. All but one said they do not specifically limit the number of contracts. The one Contractor that said it did limit the number only reduced their

agencies from a high of fifty-two, to the current forty nine, not a significant difference. In all of the states, the number, and even the specific agencies they contract with, is largely the result of historical events. In most states, the agencies that WIC contracts with now are largely the same agencies that they have contracted with since the program started. In the relatively rare instances where there have been changes in agencies, it has largely resulted from circumstances related to the particular Contractor, such as agencies closing, merging, or being sanctioned for non-performance. It has seldom been as a result of choosing a superior Contractor through a competitive bidding process.

Most of the states interviewed use a variety of types of Contractor to provide WIC services. Some, such as Colorado use primarily county health departments and county nursing services. More common are the states that use a mix of city and county health departments, hospitals, federally qualified health centers, and Community Action Programs. It appears that the types of agencies that were selected twenty five years ago were a reflection of the types of agencies that were available, interested, and capable at the time, and that the service delivery infrastructure has not changed significantly since then.

III.6.2. Grant Applications and Contracting Processes

Only two states interviewed indicated they had any type of competitive bidding process. In one of these, Massachusetts, the WIC contract is bid as part of a combined process along with other services funded by the same bureau. While Massachusetts has thirty-six (36) WIC contracts, they received multiple competitive bids in only two or three areas. In all of the remaining areas, only the incumbent Contractor submitted a proposal. Another state, Indiana, is issuing their first competitive procurement next year, but only in response to a new requirement from the State Department of Administration.

The most common length of local Contractor contract period is one year, although others issue contracts for three or five years. One state has a five-year contract with two optional two-year renewal periods. (It is assumed all of the multi-year contracts contain language allowing the state to cancel the contract if federal funds are not available.) Some states require their agencies to submit a grant application periodically, with periods ranging from one to five years. However, most automatically renew the contracts for all existing agencies each year. So, for all intents and purposes, there are no competitive processes in place for procuring WIC services in these states.

III.6.3. Service Area Issues

States were asked whether their Local Contractors had discrete service areas, or whether they had overlapping service areas. The response was mixed. Eight of the states had exclusive areas in all, or the majority, of the state. However, most had multiple agencies in one or more urban areas. In those states, other factors tended to segregate the participants of the multiple agencies. For example, Massachusetts has nine agencies in Boston, but the city is divided by neighborhoods and agencies primarily serve certain neighborhoods. Texas has multiple agencies in areas, such as Houston/Harris County. However, the city health department serves the city, the county health department serves the rural county areas, and two other agencies serve specialized populations (a situation similar to Jackson County in Missouri).

Every state interviewed had agencies with multiple county service areas. In states ranging from Indiana to Massachusetts to North Dakota, this was the rule rather than the exception. In most states, however, the agencies that served WIC over multiple counties also provided other services in the same area. Not surprisingly, it was unusual for a Contractor to provide WIC services in a broader area than the other Contractor services. Furthermore, the agencies that served multiple counties were typically not county health departments. Only one state interviewed, North Dakota, has county health departments that provide WIC in a multi-county area even though they do not provide other services in those counties. The most notable example is a county health department that has WIC offices in seven other counties that do not provide their own services. In the other states, the multi county agencies were either regional public health departments or Community Action Programs.

Although there is a large range of local Contractor sizes in these states, they tend to be somewhat larger than many of the Local Contractors in Missouri. Every state has agencies with multiple clinic sites, and that tends to be the norm rather than the exception.

III.6.4. Implications for Missouri

In many respects, the other states are a reflection of what has occurred in Missouri. The Local Contractors in Missouri reflect who has traditionally been available to provide services – county health departments in rural areas, along with hospitals and non-profit health centers in urban areas. The local Contractor population has been very stable in Missouri, as it has elsewhere. The implication of the interviews’ results is that in most states there isn’t a supply of alternate WIC agencies “waiting in the wings.” There is little precedent to know how well consolidation of local Contractor contracts would work in Missouri, since it hasn’t been attempted to any great extent elsewhere.

Most of the WIC service delivery in rural Missouri is provided by local health departments. As in other states, where county health departments are the WIC service providers, they tend to be single county operations. (There are some exceptions, such as Clinton County that also serves Caldwell County.) Most of the county health departments visited for this project indicated that their county provided financial support to WIC in addition to the contract funds. While most seemed quite willing to continue doing this as a service to their population, it is questionable whether they would be willing to take on the responsibility and financial obligation of providing WIC services in other counties. It does not fit within their current agency mission. For most areas of the state, if Missouri is interested in contracting for services on a wider geographic basis, it will probably be necessary to identify alternate Contractors that already deliver services in multiple counties. Some possible types of alternate providers include federally qualified health centers (FQHCs) and Community Action Agencies (CAAs). For this study, we inquired during our Local Contractors visits whether they believed there are other Contractors providing similar services in the area and capable of sponsoring a WIC Program. As might be expected, most of the Contractors visited indicated they did not believe there are many viable alternatives.

III.7. STATE INTERVIEWS – SUMMARY OF FUNDS ALLOCATION PROCESSES

III.7.1. State Agency and Local Contractor Budgeting Processes

Once a year, Congress appropriates funds for the WIC Program. The Food and Nutrition Service (FNS) of the United States Department of Agriculture receives the appropriation and runs a complex formula to determine how much to allocate to each state. The federal fiscal year begins on October 1, but it is often January before states learn the result of the funding formula. Meanwhile, most states have local Contractor contracts that take effect on the beginning of the federal fiscal year or the beginning of the state's fiscal year. The most common state fiscal year start date is July 1.

States typically begin their annual budgeting process several months before the contracts take effect. Several states indicated they begin planning in the Spring (April was mentioned by at least three states) for the fall contracts. The first question that must be decided is how much to put into local Contractor contracts and how much to reserve for state level operations.

States' approaches to this issue vary. Two states interviewed said they allocate funds for Local Contractors first and then use whatever is left for state agency operations. This approach is difficult in that state agency operational costs, while a much smaller portion of the total spending, tend to be more stable and less directly related to changes in overall funding and participation. State level costs are also difficult to adjust significantly without either hiring new staff or laying off existing staff, both of which are often lengthy and difficult processes in state government.

As a result, the most common solution described in the interviews is to first estimate the total amount of Nutrition Services and Administration (NSA) funds expected, then estimate how much will be needed for state level operations. The state agency budget is taken off the top, and all remaining funds are then allocated for Local Contractor contracts. Some states qualified this approach by saying that they tried to keep state level costs to a minimum, or under a specified percentage of the total.

This approach is more than just an example of the old government "Golden Rule" (i.e. "He who has the gold makes the rules"). It is actually a quite logical approach to meeting three necessary objectives:

1. Ensure that no more funds are allocated than are available;
2. Ensure that funds are available to cover all costs at the state level; and
3. Ensure that all available funds are allocated.

In developing the detailed state level WIC budget, the total of Local Contractor contracts is typically treated as a single line item or cost center, and is the last line assigned an amount.

The national NSA formula uses an "administrative grant per participant" (AGP) concept. The AGP is recalculated each year as one of the first steps in the running the formula, based on a combination of the size of the appropriation, national average food package costs, an estimate of the number of participants that can be served with the food grant, and the amount of NSA funds available. Because of the way the formula works, the grant per person received by each state can vary

somewhat from year to year. Consequently, this variation is included in many states' budgeting processes as well.

Since states' original allocation of funds to Local Contractors is based on an estimate of the amount that will be available, states have adopted a variety of practices to insure that the first and third objectives are met. These are described in the following section on allocation methodologies. Several of the methodologies include a mechanism to allocate additional funds during the year as they become available, and a mechanism to equitably reduce funding to Local Contractors in the event total funding is less than anticipated.

III.7.2. Types of Funds Allocation Methodologies

Administrative Grants Per Participant

All but one of the states interviewed (Indiana), use some form of grant per participant concept in their Local Contractor funding methodology. However, there are as many variations on this concept as there are states. Most states either use multiple grant per participant rates, or they adjust the rates by some additional factors...or both.

All of the states either use varying rates for different "bands" tied to the authorized number of participants to be served, or they have a factor that adjusts the grant per person based on caseload size. The conventional wisdom is that as Local Contractors get larger there are economies of scale that make it less expensive, on a cost per person basis, to provide services. To put it another way, they believe there are certain administrative costs inherent in managing a WIC program of any size. These costs can be distributed over a hundred participants per month, a thousand, or ten thousand participants per month.

For example, a state may use three bands in its methodology. It will fund agencies serving up to 1,000 participants per month at one grant per person amount, agencies serving 1,001 to 10,000 per month at a slightly lesser rate, and agencies serving over 10,000 at a lower rate. Or, alternately, all agencies may receive the 0-1,000 rate for that share of their caseload. Those serving over 1,000 receive the lesser rate for the number over 1,000, and so on. (The national formula works this way.) In most states, the rate for each band gets progressively smaller; however, in one state the rate for the third band is slightly higher than the rate for the second band. They believe that economies of scale work to a point, but that the largest agencies begin to incur additional overhead that drive the costs back up.

None of the states interviewed actually identified the true differences in costs between the bands. In fact, the typical process for establishing the bands was to rank all of the agencies in order by size of caseload and look for natural breaking points. The states then applied rates to each band that would equal the desired total when combined.

Rather than using bands, Michigan uses varying rates for each Contractor based on their historical cost. Another state, Texas, also does not use bands. They start with a single grant per participant figure. For each Contractor, this figure is adjusted upwards or downwards for a number of factors, one of which is caseload size.

Colorado doesn't use an identified grant per participant. Each Contractor's base grant amount is a percentage of the funding equal to their proportionate share of the total authorized caseload. This amount is then adjusted based on other factors. Although it is not calculated as a grant per participant, the net effect is the same. (It is the same principle as providing each Contractor with the same base starting rate times their caseload.)

Adjustments to the Grant Per Person

As described in the previous section, most states adjust the grant per person based on caseload size. For most of the states interviewed, this was the only adjustment made. Two states, Colorado and Texas, have adopted more sophisticated formulas. These are worth describing in detail, as they illustrate the range of possibilities.

Missouri's current methodology does not directly support the concept of "economies of scale" found in other states. However, indirectly it supports a similar concept found in other states that there are certain fixed costs that must be met by all agencies, and that once these are met expansion of caseload requires less cost per participant within that Contractor. All Missouri agencies are initially funded at the same grant per person rate. However, if a Contractor receives additional caseload authorization during the year, it is at a reduced rate. The implied assumption is that the fixed costs are already covered, and the reduced rate is sufficient to cover the additional direct salary and supply costs of additional participants.

Colorado's Funding Methodology

Colorado adopted a new funding methodology starting with Federal Fiscal Year 2001. They first determine each Contractor's "performance caseload," which is an average of the previous year's assigned caseload and their actual participation. Use of this average helps avoid large shifts from year to year. They calculate each Contractor's percentage of the total state authorized caseload, then multiply this times a salary index to adjust for differences in costs of personnel between agencies. The salary index is based on the amount a Contractor's salaries are above or below the statewide average for all WIC agencies. This calculation produces each Contractor's share of the base funding, which represents seventy-five percent (75%) of the total amount available to allocate.

An additional twenty percent (20%) of the available funds are allocated through a banding component, to account for economies of scale. Their approach to this is unusual, however. Colorado's bands are based on a comparison of each Contractor's participation and full time equivalent (FTE) staff with those of other agencies. Larger agencies, in Band A, have a higher percent of the statewide caseload than their percent of the statewide total of FTEs. Agencies are assigned to a band based on their number of FTEs. They ranked all the agencies and looked for natural breaks to group agencies with similar operations. Once the bands were determined, agencies were ranked within their band based on their caseload size.

The remaining five percent (5%) is allocated based on two additional factors: number of high-risk participants and participant turnover rate. High-risk participants are defined by the state's data system. They calculate each Contractor's percentage of high-risk participants compared to the statewide average percent. Those with higher rates receive additional funding, under the assumption that these participants require more staff time for education, counseling, and referrals.

Participant turnover is defined as the ratio of certifications to check distributions. Those agencies, primarily urban agencies, with higher turnover rates receive extra funding because it requires more time to do certifications than to do check distribution.

All of these components are built into a complex spreadsheet-based formula. The state enters in the starting dollar amount and other information and the spreadsheet does the calculations. They also have a \$75,000 travel set-aside for agencies that have to budget more than one-half percent of their budget for travel. Finally, in addition to the formula and travel set aside, they have a “minimum grant” for the smallest agencies. This is part of their transition process for implementing the new formula, and serves as a “hold harmless” feature so that small agencies did not lose any funding.

Texas’ Funding Methodology

The Texas WIC Program spent about three years working on a new funding methodology which they implemented for Federal Fiscal Year 1998. It begins with a base “grant per participant” amount that is the same for every Contractor. The amount is based on a calculation of the total funds available for allocation divided by the caseload authorization. The base amount is recalculated each year at the start of the process.

Several additional factors are then used to adjust the rate up or down for each Contractor. Each factor is treated independently. On each factor, agencies are ranked from highest to lowest. The state identifies natural breaking points in the rankings and groups agencies in bands or ranges. For most factors, those agencies in bands above the statewide mean get a positive adjustment to the base, and those agencies in bands below the mean get a negative adjustment. Agencies in the band that includes the average do not receive any adjustment. A Contractor may get a positive adjustment on one factor and a negative adjustment on another. In the end, each Contractor receives a grant per person that is the sum of the base and all the positive and negative factors. This grant per person is then multiplied times their authorized caseload.

Much of the data used is taken from the Texas Almanac. This book, published by the state government, contains extensive statistical data by county and is updated annually. The factors used are as follows:

- Population density. Texas has densely populated urban areas and wide-open spaces in West Texas. Some agencies serve several rural counties while others are located within a single urban county. They reason that it is more expensive to provide services in sparsely populated areas, so agencies with population densities below the mean (average) receive a positive adjustment and agencies with densities above the mean receive a negative adjustment. For multi-county agencies, they count how many counties have population densities above and below the mean. If more counties have densities below the mean, they get a positive adjustment, if the opposite, a negative adjustment.
- Median household income. This factor is used as a proxy for differences in the cost of hiring staff. It assumes that if overall incomes are higher in a county, the WIC Contractor will have to pay higher average salaries to attract staff. For multi-county agencies, they use the income for the county in which the Contractor has its home office, since that is where all or most of the staff live.

- Full time site equivalents. As part of their “extended hours plan” in their annual application, each Contractor submits the clinic hours for each of their sites. The state adds these hours together and divides by 172 hours, the number of hours per month for a full time site. This produces a “full time site equivalent” figure for each Contractor. Agencies with full time site equivalents above the mean get a positive adjustment. The rationale for this factor is that extended hours and additional sites provide better participant access and should be encouraged, but they are more expensive to operate than a single site open during normal business hours.
- Caseload size. This factor works in the reverse of the others. Agencies larger than the state average get a negative adjustment and agencies smaller than the average get a positive adjustment, based on an assumption of economies of scale.

In addition to these factors, they have established other conditions. For example, if a Contractor has average participation per county of less than 1,000, they use 1,000 as a base. This offers an indirect method of providing a minimum grant per Contractor. They also set minimum and maximum rates that any Contractor can receive. Currently the minimum is \$8 per participant and the maximum is \$12.

Texas methodology also has one other feature that appears to be unique. Each Contractor’s rate times its authorized caseload establishes the maximum amount that the Contractor can bill the state for. However, a Contractor must “earn” its grant each month. The Contractor can only bill for actual expenses up to an amount equal to their actual participation times their rate. For example, if a Contractor’s rate is \$9.00 and their authorization level is 1,000 per month, their spending cap is \$9,000. However, if they only serve 950 participants, the maximum amount they can invoice the state for is \$8,550., not \$9,000.

III.8. STATE INTERVIEWS – SUMMARY OF STATE AND LOCAL LEVEL EXPENDITURES

III.8.1. Sources of Data and Limitations

Interview states were asked to estimate what percentage of their overall NSA funding was allocated to Local Contractors and what percentage was kept at the state office. As a check on these estimates, states were also asked to provide information from their FFY’2001 close out FNS-798 reports. The closeout FNS-798 report includes an addendum that shows total expenditures broken out by state and local levels, and by four categories of spending. The four categories are client services, program management, nutrition education, and breastfeeding promotion and support. States were asked to provide a copy of this addendum.

The assumption made by FNS in defining these categories was that the majority of costs shown at the local level would be in client services, with a smaller amount for program management, and that the reverse would be true for state office costs. Federal regulations prescribe the minimum amounts that must be spent in a state for nutrition services and for breastfeeding promotion and support. Costs are incurred for both of these categories at both the state and local level. FNS provided guidance on the types of costs that should be included in each category. These categories have been used for approximately ten years. However, FNS has left it to each state to determine the means of

documenting costs by category. For most states the majority of expense is in personnel costs, especially at the local level. Some states developed record keeping systems using these categories, others do periodic time studies, and others simply do estimates based on activity.

The total amounts reported for state versus local costs are easily documented and are assumed to be accurate. The definitions for nutrition education and breastfeeding have been repeatedly clarified, and are probably applied fairly consistently between states. However, the costs and percentages for program management and client services should be viewed somewhat skeptically.

III.8.2. Comparison of Missouri Data With Other States

Table 11 summarizes the information from Missouri and the states interviewed for this project. All costs reflect Federal Fiscal Year 2001, the most recent year for which the information was available

For the states interviewed, the share of the funds spent by Local Contractors ranged from a low of 73%, in Michigan, to a high of 89%, in North Dakota. The percentage spent by Local Contractors in Missouri was less than any of these, at 63%.

It is difficult to make meaningful comparisons of state/local spending between states without closely examining how each state operates. Some states, including Missouri, pay for expenses such as operation of a statewide clinic automation system or clinic personnel training out of the state office budget, while in other states these may be reflected as Local Contractor costs. Some states, like Missouri, purchase computer hardware, medical and office supplies, or printing in bulk and distribute them to Local Contractors to use, while other require the Local Contractors to purchase their own. For example, most of the states interviewed indicated they purchased computer hardware centrally, to insure standardization. However, North Dakota, the state with the highest Local Contractor percentage, requires their agencies to purchase their own hardware.

All of the states interviewed purchased or paid for some items directly from the state office. Whether a state agency purchases items directly for Local Contractors to use or requires them to buy everything themselves is a management decision and is not an indication of the degree of equity from one state to another.

III.8.3. Direct, Indirect, and In-Kind Expenditures

The interview states were also surveyed to obtain information about their policies regarding use of in-kind rates and cost allocation policies. Eight of the states responded. Only one of the states (Indiana) said they do not allow local agencies to charge WIC a share of a federally approved indirect rate. For the remaining states, the percentage of local agencies that do use one ranged from 30 to 100 percent. Seven of the states also allow their local agencies to charge overhead costs based on a cost allocation plan. (Maryland does not; however, all of their local agencies have indirect rates.) All of the states require their local agencies to submit a budget at the beginning of each contract period. In all but one of the states (Texas) the budget shows how much of the projected cost is for direct versus indirect cost.

Six of the states require their local agencies to distinguish between direct and indirect cost on the expenditure reports they submit with their monthly or quarterly invoices for reimbursement. Of the states that could identify the average proportion, the range varied from 91% to 96% direct cost (9% to 4% indirect).

Only three of the states request local agencies to show projected in-kind contributions on the annual budgets. Of these, one made a point of saying that it was optional, not a requirement. Only two of these states provide an opportunity for local agencies to report their actual in-kind contributions with their expenditure reports, and only one of these was able to provide an estimate of how much was reported. The amount was negligible, less than one percent. In short, the amount of information that Missouri has regarding in-kind contributions from local Contractors is much greater than the states interviewed. It is not necessarily the case that the Contractors in the other states do not provide in-kind contributions; it has simply not been a priority of the state to collect or track this information.

States were also asked whether they considered any of the funds allocated through their methodology to be “incentive” funds. Only three of the states indicated they did, and the uses were fairly limited. One state requires their locals to serve at least 97% of their authorized caseload or they cannot get full reimbursement for their costs. Another receives funds from CDC to provide to local agencies to increase their immunization rates; however, these are not WIC funds. As explained earlier in the report, Texas considers some of the factors in their methodology to be incentives to encourage types of operational behavior (such as having increased clinic hours).



Table 11
Total Federal Outlays - FFY 2001

State	State Level Expenditures					Local Level Expenditures					Total
	Program Mgmt	Client Services	Nutrition Education	Breast Feeding	State Subtotal	Program Mgmt	Client Services	Nutrition Education	Breast Feeding	Local Subtotal	
CA	22,371,815	2,052,516	3,734,629	391,431	28,550,390	18,045,585	73,943,033	42,778,740	17,938,912	152,706,271	181,256,661
% Total Outlays	12.3%	1.1%	2.1%	0.2%	15.8%	10.0%	40.8%	23.6%	9.9%	84.2%	
CO	1,640,251	0	71,143	21,772	1,733,166	2,893,395	3,362,289	2,954,305	822,439	10,032,428	11,765,594
% Total Outlays	13.9%	0.0%	0.6%	0.2%	14.7%	24.6%	28.6%	25.1%	7.0%	85.3%	
IN	2,930,050	26,357	102,887	116,224	3,175,518	2,044,020	8,321,651	3,591,291	1,050,524	89,907,486	93,083,004
% Total Outlays	3.1%	0.0%	0.1%	0.1%	3.4%	2.2%	89.4%	3.9%	1.1%	96.6%	
MI	1,848,437	5,455,190	842,173	500,777	8,646,577	5,797,980	12,215,054	3,935,516	862,009	22,810,559	31,457,136
% Total Outlays	5.9%	17.3%	2.7%	1.6%	27.5%	18.4%	38.8%	12.5%	2.7%	72.5%	
MO	3,614,121	1,189,873	1,049,061	1,192,698	7,045,753	725,792	7,508,406	2,942,552	801,943	11,978,693	19,024,446
% Total Outlays	19.0%	6.3%	5.5%	6.3%	37.0%	3.8%	39.5%	15.5%	4.2%	63.0%	
ND	104,476	91,675	59,846	15,577	271,574	303,068	1,172,613	644,728	89,223	2,209,632	2,481,206
% Total Outlays	4.2%	3.7%	2.4%	0.6%	10.9%	12.2%	47.3%	26.0%	3.6%	89.1%	
NE	858,892	289,585	167,386	21,030	1,336,893	1,217,804	2,283,379	865,525	152,916	4,519,624	5,856,517
% Total Outlays	14.7%	4.9%	2.9%	0.4%	22.8%	20.8%	39.0%	14.8%	2.6%	77.2%	
PA	8,691,114	0	309,746	109,322	9,110,182	5,931,626	13,112,929	5,560,033	1,288,494	25,893,082	35,003,264
% Total Outlays	24.8%	0.0%	0.9%	0.3%	26.0%	16.9%	37.5%	15.9%	3.7%	74.0%	
TX	18,432,075	1,271,045	1,731,958	845,783	22,280,861	14,849,726	42,752,004	21,664,628	2,317,903	81,584,261	103,865,122
% Total Outlays	17.7%	1.2%	1.7%	0.8%	21.5%	14.3%	41.2%	20.9%	2.2%	78.5%	
US Total – 1999	60,491,231	10,376,241	8,068,829	3,214,614	82,150,914	51,808,996	164,671,358	84,937,318	25,324,363	326,742,036	408,892,950
% Total Outlays	14.8%	2.5%	2.0%	0.8%	20.1%	12.7%	40.3%	20.8%	6.2%	79.9%	

III.9. INTERNET SEARCH OF POPULATION DATA AND STATISTICS

Although it was not part of the original scope of work, BCA conducted a search for data available on web sites maintained by the State of Missouri, as well as comparable data maintained by outside entities, such as the Federal Census Bureau and University of Missouri Extension. As explained in the previous sections, states such as Texas rely on population-based data for their funding methodology. Missouri does not have the equivalent to the printed Almanac used by them. However, with the proliferation of data available on public web sites, it was suspected that much of the same information would be available through that avenue.

Extensive information is published by various state agencies in Missouri, including the Missouri Department of Health and Senior Services. For example, one of the alternative methodologies described in Section V uses average salaries by county as published by the Missouri Department of Economic Development.

IV. FUTURE MISSOURI WIC FUNDING AND BUDGETING

IV.1. HISTORICAL MISSOURI SHARE OF FEDERAL WIC FUNDS

The history of WIC funding nationally over the last thirty years has been one of tremendous growth, from a \$20 million a year pilot program to a FFY'2002 appropriation level of \$4.422 billion. For most of that period, the goal has been to reach “full funding,” the point at which there are enough funds to serve the entire eligible population. One effect of that growth was that, while there was never “enough” funding, there was usually more than there was the previous year, and more could be expected the following year. This made the allocation of funds among states easier, as there were usually enough funds to provide cost of living increases as well as “growth” funds to those states that needed them. States served disproportionate shares of their eligible population, and one goal of the national formulas was to reduce this disparity. Several of the national funding formulas used over the years assumed the availability of growth funds to meet this goal. States also benefited from this steady increase in allocating funds among their Local Contractors.

During the last half of the 1990's, many states began to believe they had finally reached a level that could be considered “full funding.” In spite of states' outreach efforts, caseload increases began to level out. During the late 1990's the amount of unspent food funds nationally reached all time highs, and Congress responded by providing only modest increases in appropriations. The size of the WIC eligible population is very sensitive to changes in the economy, however. In the last two years, many states have seen demand for WIC services start to increase again.

In FFY'1999, Missouri's share of the national NSA appropriation was equal to 1.61%. It was 1.58% in FFY'2000, 1.63% in FFY'2001, and is currently, 1.61% in FFY'2002.

IV.2. ANTICIPATED FUTURE WIC FUNDING AND MISSOURI SHARE OF FUNDS

In deciding how best to allocate funds among Local Contractors in Missouri, it would be helpful to have a crystal ball to know what level of funds the state could anticipate having to work with. Obviously, that is not possible. However, it is possible to make an educated guess about the overall trend in funding and Missouri's share of those funds.

Nationally, the WIC Program has weathered several political attempts to either reduce its funding or convert it into a block grant. The most recent of these was in the mid-1990s. In the end, the Program was left intact, and, as mentioned above, continued to receive some increases in funding.

The current administration has proposed reducing spending on a number of domestic programs that it considers ineffective. However, it has also held up a handful of programs as models for how federal programs should function. Chief among these model federal programs is the WIC Program. To demonstrate its support of the program, the administration has proposed an increase of \$364 million in WIC funding for FFY'2003. Congress is expected to support this request.

While it is not safe to assume that WIC will receive such large increases in funds every year – there is no indication that they would be needed – it is reasonably safe to assume that food funding for the

WIC Program will generally be sufficient to meet demands. There is no reason to anticipate any reductions in funding.

A longstanding goal of the national funding formula has been to reduce the disparities in funding between states, eliminating the long-standing notion of “under fair share” states. It is believed within FNS that with the appropriation increase slated for next year, this goal will have been met.

One effect of this attempt to reduce the disparity has been that most states’ share of the appropriation changed from year to year. Those states under their fair share received a larger percentage each year, while those over fair share received a slightly smaller percentage. In the future, however, states’ percentages of the national appropriation should be relatively stable. Missouri can reasonably expect to receive just over 1.6% of the NSA funds available to states.

IV.3. IMPLEMENTING A REVISED FUNDS ALLOCATION PROCESS

The biggest challenge facing states in changing their methodologies for allocating funds among Local Contractors is providing more funds to those Local Contractors that warrant them, without negatively affecting the delivery of services in other Local Contractors as a result of reducing their funds. With a fixed amount of funds to work with, a change in methodology typically results in winners and losers.

As pointed out in section IV.3, Missouri appears to be ideally situated to make changes in the allocation process, because it has had some unused funds in each of the last two years. Even so, Missouri should consider some type of phase in process for the new allocation methodology. Some increase in the grant per participant rate is warranted for FFY’2003, using the current allocation process. We would caution against allocating all of the additional funds that are estimated to be available, however. The Department should allocate just enough to avoid returning any unspent funds to USDA at the end of the year. If some of the unused funds are kept in reserve, they can be used to make the transition to a new methodology easier and less painful.

V. FUNDS ALLOCATION METHODOLOGIES

V.1. PRINCIPLES OF FUNDS ALLOCATION

Simply put, there is no one correct way to allocate funds among Local Contractors. If there were, there would not be a different methodology used in all fifty states. Whether recognized or not, a state's allocation methodology carries with it some "values." Most approaches try to be objective; however, they often subtly encourage, or discourage, certain management behavior. Some aspects of the methodology may reflect a desire to increase the availability of services or enable Local Contractors to pay higher salaries to staff, both of which are value judgments.

Before trying to decide on a new allocation methodology, it is useful for a state agency to identify a set of underlying principles and share them with the Local Contractors. Some principles may be contradictory to other ones, and without a common understanding of what the methodology is trying to accomplish, Local Contractors may complain endlessly about the details of the new methodology without understanding the objectives it is intended to accomplish.

Following are several examples of funding allocation principals. These are presented here for illustration, not as recommendations:

- The allocation methodology should fully allocate all anticipated funds.
- The allocation methodology should recognize economies of scale.
- The allocation methodology should provide sufficient funds to all Contractors, including the smallest ones, to insure the ability to meet all program requirements.
- Providing adequate access to services is important. Therefore, the allocation methodology should enable Contractors to provide sufficient clinic sites and operating hours.
- The allocation methodology should recognize cost differences that are beyond a Local Contractor's control, but should not recognize differences that are a result of management decisions regarding service delivery.
- The allocation methodology should recognize inherent differences in the cost of delivering services related to the type of WIC Contractor the contract is with.
- The allocation methodology should recognize the availability of (or lack of) other entities that can provide some of the information required for certifications (e.g. height/weight/hemoglobin). For example, rural counties may have no health service providers to supply this information.
- The state agency should reserve the right to negotiate increase or decreases from the amount identified by the allocation process if special circumstances warrant it.

Each of the three alternative methodologies described in section V.7. embody one or more of these principles. Typically, the more principles that a state adopts, the more complicated the allocation methodology becomes.

V.2. ROLE OF IN-KIND CONTRIBUTIONS BY LOCAL CONTRACTORS

In the course of this project, BCA examined both the amounts and types of in-kind contributions reported by Local Contractors. A large majority of the in-kind contributions reported were for salaries, particularly for management staff above the level of the WIC supervisor. This is not surprising, as the amount of grant funds in many of the Local Contractors visited were sufficient only to pay the direct program salary costs. Since all Contractors have payroll systems, in-kind costs are relatively easy to document. It is quite possible, however, that Contractors provide much value to WIC in the form of free office and clinic space that is simply not calculated, documented, or reported anywhere.

It should be noted that none of the principles suggested in section V.1. deal with issues of in-kind costs, or even whether the WIC funds should cover all of the cost of Local Contractor services. This is because the amount of funds provided through the allocation methodology is largely beyond the state agency's control. Generally, the goal of the methodology is to allocate all available funds as equitably as possible. The receiving Contractor then must decide whether it can operate and meet program requirements on the grant funds alone, or whether it must contribute financially from other resources. If the Contractor decides it must contribute to the cost, it then decides which items to bill to the WIC grant and which to pay for itself. Typically, direct expenses are charged to the grant and indirect costs or overhead are picked up by the Contractor. The only requirement should be that any in-kind contributions reported to the Department are for WIC-allowable items. Local Contractor management decisions are typically not reflected in the allocation methodology, nor should they be.

V.3. SERVICES PROVIDED BY LOCAL CONTRACTORS AND THE STATE WIC OFFICE

In general state and local roles are well defined in federal regulations, and do not vary significantly from state to state. The two areas in which states differ the most in the division of responsibilities have to do with retail vendor management and in outreach.

Some states delegate a significant role in vendor management to Local Contractors while others centralize all responsibilities in the state office. Either approach can be effective. In those states that delegate responsibilities to Local Contractors, the total funds may indirectly reflect this, as the state office budget may be slightly smaller and the total of Local Contractor contracts slightly larger. However, there does not appear to be any state that specifically references these responsibilities in their allocation methodology. Consequently, this does not appear to be a significant issue in providing recommendations for Missouri.

The same situation applies to outreach responsibilities. While some states are more specific than others in the type of outreach activities required of Local Contractors, this project did not identify any states that earmark funds specifically for this.

More importantly, there is no correlation between the division of responsibilities between the state agency and Local Contractors and the three alternative funding methodologies described below. In other words, they are entirely separate issues.

The standard services that all Local Contractors are required to provide are prescribed in detail in the Program's Policy and Procedure Manual. These requirements are irrespective of the funding methodology, and should remain that way. Therefore, the services required of Contractors under each of the alternative methodologies are the same. Contractors that desire to undertake additional responsibility in the form of special projects currently apply for special project grants. The three alternatives retain this process; however, the special project grants are more specifically identified as being intended to provide incentives for enhanced performance. In the first two alternatives, the funding for the special projects is treated as a separate grant, as it is currently. Under the third alternative special project would not be separate grants, but the dollar amount associated with them would be separately identified in the budget.

V.4. AMOUNT OF STAFF TIME REQUIRED FOR DELIVERY OF SERVICES

The amount of time required to complete a certification or provide nutrition education classes or any of the other services provided by the WIC staff to the WIC applicant or client is not dependent on or directly related to the funding methodology in place. Therefore the staff time requirements would be the same under any of the methodologies used to allocate funds to the Local Contractors. A number of different other factors do greatly influence the time requirements. Some of these factors include:

- The training level of the staff providing services – A staff person with six months or less of experience in the WIC clinic would not be as familiar with the policies and procedures requiring them to spend time looking up or calling for assistance on certain issues. While a new staff person often provides a very thorough assessment they are not as familiar “with the routine” and thus require longer to complete the task.
- The FTEs (full time equivalents) of WIC staff available to provide the services. – A clinic that is grossly under-staffed with an inadequate number of FTEs compared to the clinic caseload will not be able to provide the WIC services efficiently because they will simply have more WIC clients to serve than time allows.
- The physical arrangement of the clinic – A WIC site arrangement where the exam room is at the opposite end of the building as the WIC clerk's area or a physical arrangement requiring the WIC participant to return to the waiting room between each step of the service delivery process (i.e.: applicant goes to clerk's station then must move herself and children to the waiting room to wait for the medical assessment, then back to the waiting room to wait for the nutrition assessment, then back to the waiting room to wait for the clerk to see her again to provide her the food instrument.) Each of these moves back to the waiting room adds a minimum of 5 minutes to the client's time and several minutes of staff time while they go to the waiting room to escort the applicant back to their station.
- The client flow of the individual clinic sites – In addition to the physical setting of the clinic how the staff have arranged the flow for the WIC client plays a part in the amount of time

required to complete the service delivery. For example, by having the WIC staff move to the clinic room rather than moving the WIC family minutes can be saved.

The size of the clinic caseload – It is generally recognized that certain efficiencies exist in a larger clinic due to additional staff being available to provide the services and minimizing downtime. There are exceptions to this also, because, a one person WIC clinic with a very small caseload can operate extremely efficiently because no time is spent waiting for the next step of the service or no time is spent explaining important pieces of information about the client to other WIC staff.

- The location of the clinic, co-located versus stand alone clinic site – While many efficiencies are enjoyed when a WIC clinic is co-located with a public health or hospital site (i.e., improved referrals by taking the person directly to the service being referred to; enhanced ability to reduce costs by sharing health data), some slight drawbacks regarding time may occur (additional time is required to escort the client to the other service).
- The clients themselves – No show rates greatly influence the downtime of the staff and subsequently the time requirements to provide the services to the entire caseload. (One of the most common responses regarding challenges of managing their WIC program was that of getting the clients in for their appointments.)

During the Local Contractor visits, Contractors were asked if they had ever conducted time studies in the WIC clinic. In response to this question twelve clinics responded yes. However, of those twelve all responded it was done years ago, or they were unsure if they actually were completed, or they were not aware of the results. Only one site said time studies had been done recently and the staff was aware of the results.

As stated above, one of the factors affecting the amount of time required to complete WIC service delivery is the clinic flow. In addition to time studies at the LA, completion of client flow analysis is recommended. A look at issues such as how often a client has to return to the waiting room to wait for the next service, how often they have to gather up the children and the items they are carrying and how far they have to walk from one service delivery area to the next will be issues to look at. Each site visited was asked Question #56, “Describe the patient flow in a typical clinic.” All describe the basic process of the client seeing the clerk, followed by the completion of the medical assessment, followed by the nutrition assessment and counseling followed by printing the checks and providing any further information the client needs. It was noted in one response that the clerks could also do heights and weights, if needed, when the nutritionist got behind schedule. Some clinics, if physically large enough, have the clients wait in the examine rooms for the nurse or nutritionist rather than having the client return to the waiting room between each station stop. Clay County stated they plan on piloting a direct data entry system. They are optimistic the direct entry of client data will make the clinic flow much more efficient.

Following is an estimate of the times required for delivery of WIC services: For a single new WIC applicant, 10 minutes for intake, 15 minutes for the medical assessment, 15 minutes for nutrition assessment and counseling and another 10 minutes for the receipt of the food instruments, training on the use of the food instruments and arrangement of the next appointment would be needed. A single recertification appointment would require 5 minutes less per process step because the client would be familiar with the routine and less information

would need to be gathered by the WIC staff. Each additional person in the family applying for WIC benefits would require an additional 5 minutes per person per station. The time requirements for delivery of nutrition education and printing of the food instruments for check pickup depends on the type (individual versus group) and average length of classes provided. The WIC fiscal person would need a couple hours per week to tally timesheets, and several hours per month to complete the WIC-24 and other required reports. The WIC clinic supervisor would require a couple hours per week to complete staff schedules, address state office required management issues and coordinate with other programs within the Local Contractor if applicable.

These figures presented here are not to be considered recommendation of times required but rather as guidelines to begin to look at the individual needs of the Missouri Local Contractors. Time studies, patient flow analysis and a comparison of FTEs and caseloads in each of the Local Contractors needs to be obtained and compared to make a true recommendation of an accurate time required per clinic and per staff position within the clinic.

V.5. GENERAL IMPLEMENTATION REQUIREMENTS

Each of the alternatives discussed below will require some type of phase in process, some more than others. Adopting any alternative will require considerable lead-time, beginning with an information sharing process between the state office and the Local Contractors. Three of the four alternatives presume a significant shift in funds between Local Contractors. Consequently, the state office needs to insure that the phased implementation does not overly disrupt the delivery of services in any Contractor.

V.6. ASSESSMENT OF CURRENT ALLOCATION METHODOLOGY

Section II.3 described some of the limitations of the current allocation methodology. Before describing the potential alternatives, it should be noted that the current process is in line with many of the principles of funds allocation. First it allocates funds proportionate to the size of the caseload in each Local Contractor. While this may work to the disadvantage of small Local Contractors, the purchase of computer hardware and other supplies probably helps offset this and even out the disparity. Plus, the special project grants can indirectly compensate for unusual circumstances as well as fund special initiatives. Part of the difficulty in the last four years has been in the context of the overall budgeting process, not just in the way the allocation process itself has worked.

V.7. ALTERNATIVE ONE

V.7.1. Description of Methodology

The first alternative methodology is based on the concept most commonly found in other states and in the national funding formula, the use of an administrative grant per participant. It also includes a principle used by many states along with USDA, which assumes that there are economies of scale in the operation of a Local WIC Contractor. This principle holds that because larger Contractors can amortize their overhead cost over more participants and can often use staff more efficiently, they can afford to operate with a lower administrative cost per person.

In this alternative, the Department would first determine how much administrative funding was available to allocate to Local Contractors through this methodology and the size of the statewide caseload the food grant would support. Then it would calculate an average, statewide “administrative grant per participant” that could be supported.

Next, all of the Contractors would be ranked in size, from largest to smallest, based on their requested and approved initial caseload for the new contract period. Contractors would then be divided into five groups or “bands.” The Department would adjust the average administrative grant per participant up or down on a percentage basis for each band. The amount of administrative funds per participant would be highest for the smallest Contractors in the first band and get progressively lower for the largest Contractors in the top band. (The percentages used take into account the number of Contractors and total amount of caseload in each band so that the overall amount of funds allocated is approximately the same as with the statewide average.) The base administrative grant for each Contractor would equal the rate for its band times the authorized caseload for the new contract period.

The other states (and USDA) that use this approach do not attempt to calculate the actual cost differences between Contractors of varying size to determine how many bands to create, where to create the divisions between bands, and how much difference in grant per participant to provide each band. Generally, states typically decide to create three to five bands and to find natural “break points” in the rankings.

Final authorized caseloads for FFY’2001 were studied to determine an appropriate number and division of bands for Missouri. The caseload size of Contractors in Missouri varies drastically. In FFY’2001, the statewide average (mean) was an annualized level of 12,756. However, the tiniest Contractors had only 9% of this average, while the largest had 781% of this number. Smaller Contractors are the norm, while larger Contractors are the exception; fully two thirds (80 out of 119) Contractors are below the statewide average.

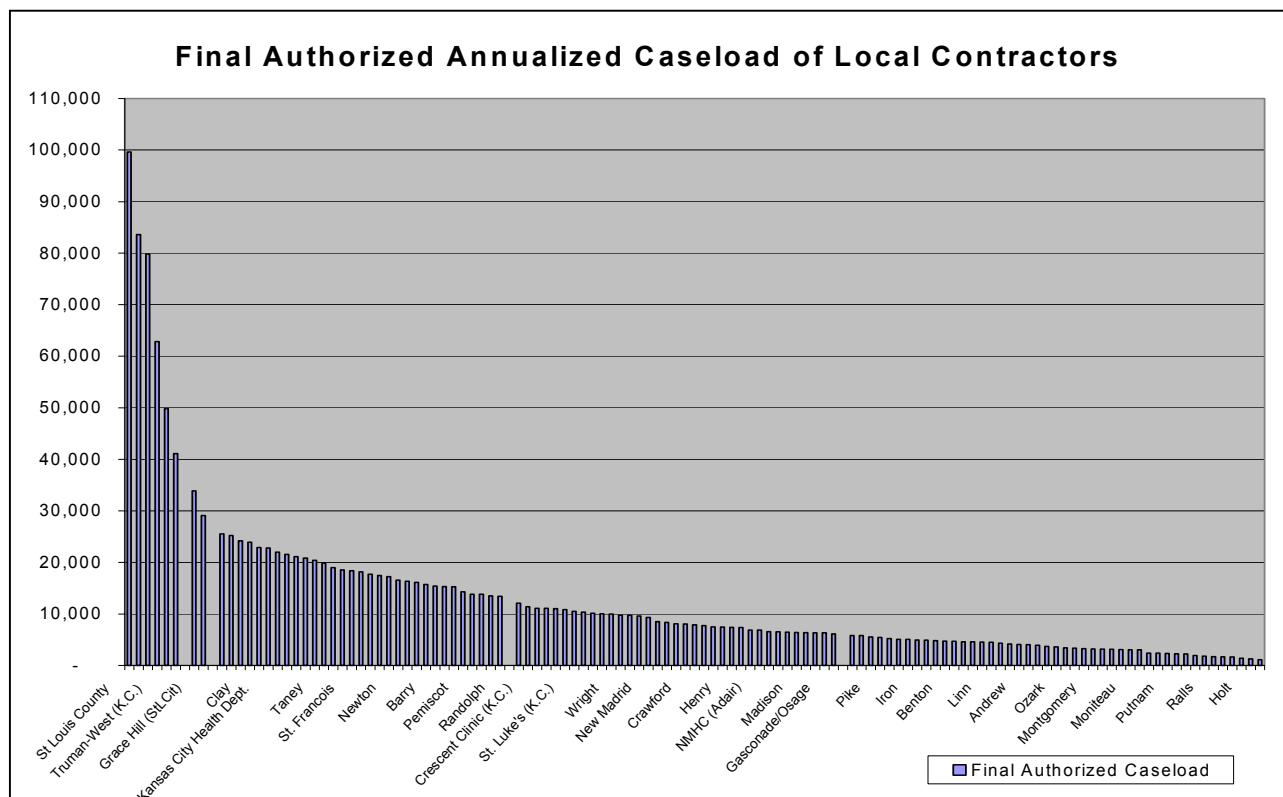
Annualized caseloads range from a low of 1,110 to a high of 99,600. The bar chart in Figure 1 illustrates the range of sizes. [Note: In addition to the bar chart, the Tables in Appendix A illustrating funding levels for all of the Contractors also show participation for each agency.] The chart drops rather steeply from the relatively small number of very large Contractors on the left of the chart and then slopes down gradually for the majority of the Contractors.

Based on this size pattern, one possible number and division of bands could be as follows:

Band 5	39,001 to 100,000	Number of Contractors in Band:	6
Band 4	26,001 to 39,000	Number of Contractors in Band:	2
Band 3	13,001 to 26,000	Number of Contractors in Band:	31
Band 2	6,001 to 13,000	Number of Contractors in Band:	35
Band 1	0 to 6,000	Number of Contractors in Band:	45

The blank spots in Figure 1 below illustrate the divisions between the bands. In this approach, the 67% of the Contractors that are below the state average are divided into two bands. The next 26% of the Contractors starting at the state average and going up in size from there are in one band. The largest 7% are divided into two more bands even though they represent only eight (8) Contractors because of the significant differences in size between them.

Figure 1—Final Authorized Caseload



The next step was to determine what level of grant per participant could be assigned to each band. This step involved a degree of trial and error. The final grant levels for FFY'2001 divided by the final authorized caseloads equaled an average grant of \$7.79, just slightly higher than the initial formula amount of \$7.75. The total dollars allocated through this approach were \$11,824,019. The five amounts for each band times the total caseload in each band should equal the same approximate total as the current methodology. The amounts in Table 12 accomplish this within about \$17,500.

Table 12 – Summary of Alternative One Allocating FFY'2001 Funding Level

FFY'2001 Final Authorized Caseload and Grant Levels	Administrative Grant Per Participant	Grant Per Participant as % of Original	Number of Dollars Allocated	Total Increase or Decrease for Local Contractors in Band
Original Level	\$7.79		\$11,824,019	
Band 5	\$6.70	86%		(\$494,649)
Band 4	\$7.09	91%		(\$41,671)
Band 3	\$7.87	101%		\$69,042
Band 2	\$8.65	111%		\$269,773
Band 1	\$9.11	117%		\$214,958
Total All Bands	\$7.79		\$11,837,581	\$17,454

The overall effect of this approach is to shift \$536,320. in funds from the eight largest Contractors and distribute most of them to the eighty Contractors that are below the state average in size. The thirty-one Contractors slightly above the state average in size would receive a nominal increase.

Missouri had \$570,531 in unused administrative funds in FFY'2001. If these funds had been allocated to Local Contractors using this methodology, the proposed bands would have looked more like that depicted in Table 13.

Table 13 – Summary of Alternative One Allocating All Available FFY'2001 Funds

FFY'2001 Final Authorized Caseload and Grant Levels	Administrative Grant Per Participant	Grant Per Participant as % of Original	Number of Dollars Allocated	Total Increase or Decrease for Local Contractors in Band
Original Level	\$7.79		\$11,824,019	
Band 5	\$7.01	90%		(\$363,784)
Band 4	\$7.40	95%		(\$22,053)
Band 3	\$8.26	106%		\$293,512
Band 2	\$9.04	116%		\$386,739
Band 1	\$9.50	122%		\$277,870
Total All Bands	\$8.17		\$12,395,303	\$571,284

Once the base administrative grants are determined through these bands, the SA would award special project grants in much the same fashion as it does currently. Special project grants are useful for a couple of reasons. The opportunity to apply for special grants can be an incentive for Local Contractors that perform well and have the initiative to try new ideas or approaches to

providing services. They can also be used to compensate Local Contractors for special circumstances or the cost of one-time needs.

In this alternative, the state would also continue to purchase computer hardware and software, lancets for Hemocues, and printed educational materials.

To use this methodology in actual practice, each year the Department would enter the initial authorized caseloads for each Contractor into a spreadsheet and prepare a graph similar to that shown in Figure 1. The graph would be compared to the bands to determine if any minor adjustments to the bands should be made. The individual grant per participant amounts for each band may also need to be adjusted by altering the percentages in each band slightly to make the overall amount of dollars allocated balance with the amount available.

V.7.2. Costs, Benefits and Limitations of Methodology

The overall cost to the Department of using this funding methodology is not inherently different than the overall cost of the current methodology. As described in Section V.3., the services to be provided by Local Contractors do not vary based on the allocation process. This methodology distributes the same amount of funds to meet the same requirements, but in different proportions. The one significant difference is that the current methodology uses the same grant per participant for multiple years. This alternative assumes that the average grant per person will be recalculated every year as the first step in the allocation process.

The primary benefit of this methodology is that it provides small and very small Contractors with modest increases in revenues. In the example of this alternative that allocated the same amount of funds as in FFY'2001 (see Appendix E), the state's smallest Contractor would see their \$8,769 final grant increase by \$1,347, a 15.4% increase. The largest Contractor in the band with the smallest agencies, Band 1, would receive a \$7,307 increase in their \$45,751 grant, a 16% increase. Very small agencies have such limited budgets, it is difficult to argue with the proposition that they need additional funding.

The obvious disadvantage to the eight largest Contractors in Bands 4 and 5 is that they would lose significant amounts of their current revenue. The largest Contractor's grant for FFY'2001 would have been \$140,467 less than their actual final grant (not including special project funding), a 17.4% decrease. The smallest of these eight large agencies would have lost \$19,259, an 8.5% decrease. Even if it is true that large Contractors should be able to operate on a lower cost per participant than small Contractors, these Contractors tend to use all or most of the grant funds available to them currently, and would probably argue that all of these are needed for their operation. If they were forced to reduce their budgets by up to 17%, as the largest would have to do, it could negatively affect their ability to deliver the same level of services.

Any new funding methodology will result in a redistribution of funds between Contractors, so the simple fact that some Contractors lose funds is not a disadvantage of this alternative compared to the other two alternatives presented. The biggest drawback to this approach is that the primary justification for making adjustments based on caseload size – the concept of economies of scale – has not been quantitatively measured by other states, nor USDA. It is a widely accepted concept, but is usually applied somewhat arbitrarily. Since the funds for all Missouri Contractors have been

artificially capped at essentially the same level, it is difficult to test this concept by looking at past spending patterns of grant funds. It may be possible to get some indication of the relative sufficiency of funding for different size agencies by looking at the types of expenses included in their annual Local Contractor plans. It could be argued that Contractors who are able to budget and spend for items such as staff continuing education, out of state conferences, or clinic renovations must be better funded than agencies that can only budget for clinic staff salaries and supplies. Some Department staff that have reviewed Local Contractors plans for a number of years reported observing that the larger agencies tend to budget and spend for more of these items, which would lend support to the concept of economies of scale.

Examining differences in total reported program costs may also provide some clues. However, these have to be viewed somewhat skeptically, as all Contractors do not report them equally, and some Contractors may have more innate ability to provide financial support.

In FFY'2001, of the ninety-four Contractors that reported at least some in-kind costs, the total program cost divided by the final authorized caseload worked out to an average of \$8.89. The highest cost per participant was \$15.94. These Contractors were ranked from highest cost per participant to lowest and labeled with the band that they would be assigned to under this alternative. There were 16 band one Contractors in the top (most expensive) third; 13 Contractors in the middle third, and 10 Contractors in the lowest (least expensive) third. For band two Contractors, there were six in the top third, ten in the second, and eleven in the third. For band three, there were nine, six, and eight, respectively. There were no band four or five Contractors in the most expensive third, one of each in the middle third, and two band five Contractors in the lowest third. Thus, these numbers provide some marginal support for the notion that costs per participant tend to be higher in small Contractors.

There is one more issue with this approach that should be considered. In deciding whether to approve the authorized caseload levels that Contractors request for the coming year, Department staff take into account a Local Contractor's current and projected year-end participation, and make a subjective decision whether the level requested is reasonable. Because this funding approach relies primarily on the use of bands, Contractors at the bottom of a band could request slightly smaller caseload authorizations for the coming year in order to qualify for the higher rate in the lower band. If this tactic became widespread, it could undermine the integrity of the process and negatively affect the program. There will be somewhat more pressure on Department staff to insure that this doesn't happen.

V.7.3. Implementation or Transition Requirements

If the national appropriation, and Missouri's share of it, increases sufficiently, it may be possible to adopt this alternative without any Contractors losing funds relative to its current level. However, that is unlikely. More likely is that a few large Contractors would get a reduction, but of a lesser magnitude than shown in the example using FFY'2001 funding levels. Missouri should build in a cap on the percentage amount of decrease that any one Contractor is subject to; for example, five percent. If the amount of funding increase were not sufficient to support the cap on the decreases, the SA would then impose a similar cap on the amount of increases provided to other agencies. The cap could remain in place indefinitely, but would have little effect after the first two or three years.

This methodology can be easily built into the spreadsheet file mentioned in Section V.7.1. to allow the Department to run “what if” scenarios. The Department could enter the current numbers into the spreadsheet and see the results first, and then apply the necessary cap.

V.8. ALTERNATIVE TWO

V.8.1. Description of Methodology

The second alternative also uses the principle of allocating funds on a grant per participant basis, with caseload size as a primary adjustment factor. However, it recognizes that other factors also influence Local Contractor costs. Five additional factors are used to adjust the rate for individual Contractors: Salary differential, number of clinic sites, participant to staff ratio, caseload turnover, and geographic area served by the Contractor. Each of these are explained in detail below, following a summary of the methodological process. At the end of the report, Appendix E contains a table illustrating this approach. The table uses actual current Local Contractor data; however agency names are replaced by alpha designations to focus attention on the mechanics of the formula rather the effect on specific agencies. In the description of the methodology and the factors, the column letter references refer to this table. As in alternative one, the state would provide funds for special projects over and above the approach described here.

Methodological Process

The methodology contains five steps. In the first step, the state agency determines the total amount available for the base contracts. This is divided by the total authorized caseload to determine the average statewide administrative grant per participant. (not shown on the table). This is the “Base Grant Per Participant” in Column B.

For the second step, Contractors are ranked by caseload size from largest to smallest and assigned to bands (Column E). The same bands as shown on page 62 for alternative one are used. The percentages (in Column F) are adjusted slightly to shift a smaller total amount of funds, to accommodate the funds that are shifted through the other factors. Each Contractor is assigned an “adjusted base rate” based on their band. The adjusted base rate for the bands containing for larger agencies is below the statewide base rate and the adjusted base rate for bands containing smaller agencies is higher than the state average. Column G shows the amount of this adjustment. The result is an Adjusted Base Grant for each agency (Column H).

In the third step, an increase or decrease is calculated for each Contractor for each of the individual adjustment factors. Adjustments are equal to one or more percent of the statewide base rate. Adjustments are calculated on the base rate rather than the adjusted base rate by band so that a one percent adjustment is the same for each Contractor. (Column C shows the amount equal to one percent of the base rate.) Each factor is based on a comparison of the individual Contractor with the statewide average for that factor. The amount of adjustment is based on the proportionate difference between a Contractor’s number and the average for all Contractors. (Columns I through AA show the calculations for each of the factors explained below.)

In the fourth step the total positive and negative adjustments for each Contractor are summed (Column BB) and added to the adjusted base rate for that Contractor. This “Final Grant Per

Participant” (Column CC) is multiplied times the Contractor’s authorized caseload for the year (Column D) to provide the final grant amount (Column DD).

Bands

Contractors of varying sizes are grouped into five bands by ranking them from largest to smallest. To reflect the increased efficiencies and economies of scale found in larger agencies, the grant per participant is reduced for the agencies above the statewide average caseload size and increased for agencies below the averages. This is the only factor that groups agencies. As will be seen in the following discussion, the remaining adjustments in this alternative treat agencies individually using percentages of a statewide average rather than bands. This approach is not practical for the size adjustment due to the extreme variance in percent of the statewide average. For the size adjustment, grouping Contractors into bands is a more practical approach. Columns E through H show the calculations for the bands.

Personnel Cost

This factor shifts funds to those Contractors located in counties with higher than average salary costs. The Missouri Economic Research and Information Center maintains a Web site containing salary information by occupation compiled by the U.S. Bureau of Labor Statistics. Counties are grouped by region. For each region, the average (Mean) salary for Registered Nurses was used for comparison. A single occupation needed to be selected, and nurses are the most common classification used by WIC for which statewide data is available. The site also contains data for nutritionists; however, the numbers are much smaller and more variable. For each Contractor, the salary level for the region containing the county in which the Contractor is located is divided by the statewide average salary level to determine the county’s percent of the statewide average. (The salaries by agency are shown in Column I and the percent of the statewide average is shown in Column J.) For Contractors that serve multiple counties, the county in which their home office is located is used for the calculation, since that is presumably where all or most of the employees reside. For each percentage point that a Contractor’s average salary cost is above the statewide average it receives one half percent of the base rate. For each percentage point it is below the state average it loses one half of a percent of the base rate. (The results of this calculation are shown in Column L.)

Salaries comprise the majority of the expense of operating WIC clinics. Differences in salary costs for WIC Contractors largely tend to mirror differences in overall salary costs for the county. Average county salary costs varied from a low of 78% to a high of 115% of the statewide average. Since personnel costs make up such a significant portion of the overall budgets (typically 80% to 90% of the total), these differences have a significant impact on Contractors’ ability to staff their clinics.

Number of Clinic Sites

Every Contractor operates at least one clinic site. In this factor, Contractors are awarded additional funds for operating additional clinic sites. A Contractor receives a one tenth of one percent increase in the base rate for each clinic site in excess of one. For example, a Contractor with six clinic sites would receive a .5% increase. Since the formula is executed before the following year’s LAPs are submitted, this factor is based on the current year’s clinic structure. If a Contractor proposes a

change in the number of clinics as part of its LAP, the funding formula will not recognize this until the following year.

There are two basic reasons for including this factor, customer service and cost. Contractors typically determine the number and location of their clinics based on a combination of where their population is located, where their Contractor provides other services, and what they can afford to provide. As a general rule, more clinics provide greater participant access to services than fewer clinics and should be encouraged, within reason. However, it is usually more expensive to provide services to a thousand participants divided between three clinics than it is to serve the same number in one clinic site. Staff can be used more efficiently in a single site, rent and utilities are less (if the Contractor has to pay these), and less supervision is required.

This factor is intended to help offset the additional cost of operating multiple clinic sites. It does not, however, provide enough additional funds to encourage Contractors to open unneeded clinic sites.

No distinction is made here between full and part time sites. If desired, the state could begin collecting detailed information on hours of operation for individual sites and use this to calculate the number of “full time site equivalents” (FTSE) for each Contractor. However, since some Contractors with only one or two part time clinics would show less than one full time equivalent, the methodology would have to be altered somewhat. The adjustment factor would be applied to the total of all FTSEs instead. Columns M and N show the calculations for this factor.

Participant to Staff Ratio

For this factor, agencies that have a greater amount of staff, as shown by having a smaller than average ratio of participants to staff receive additional funds and agencies with a smaller amount of staff (and thus a larger participant to staff ratio) than average lose funds. For each Contractor, the current authorized annual caseload is divided by the full time equivalent staff shown in the current year’s Local Contractor Plan to produce a ratio of participants to staff. (Column N shows the number of FTE’s.) The figure in Column D is divided by Column N to produce the ratio shown in Column P. Only the WIC coordinator and WIC staff are included in the calculation, but these staff are included whether funded by the WIC grant or through in-kind contributions. Contractor’s administrative staff are not included.

Caseload and FTEs for all Contractors are totaled at the bottom of the respective columns and the statewide ratio is calculated (Bottom of Column P). For each Contractor, the percentage of the statewide ratio that their individual ratio equals is calculated (Column Q). For each percentage point that a Contractor’s ratio is below the statewide average it receives an increase equal to one tenth of a percent of the base rate. For each percentage point it is above the state average it loses an amount equal to one tenth of a percent of the base rate (Columns R and S). For example, an agency who’s ratio is 10% above the state average would have its rate decreased by one percent, or \$.079.

The staff responsibilities in large and small Contractors are essentially the same, and the amount of time required for specific tasks should not be affected by the size of a Contractor. However, larger Contractors tend to be able to use staff more efficiently. To illustrate, caseload to FTE ratios were calculated for all Contractors. Contractors were then ranked from largest to smallest based on

caseload. For Contractors in the largest quarter of the Contractors, the combined ratio was 113% of the statewide average. Contractors in both of the middle two quarters had combined ratios of 94% of the state average, and Contractors in the lowest quarter (the smallest Contractors) had combined ratios only 91% of the average.

The reason smaller Contractors are generally unable to use staff as efficiently as large Contractors is probably due to the imperfect ability to match part time personnel to part time clinics.

Overall, this factor tends to shift funds from larger to smaller Contractors, with the majority of the shift coming from the largest ten percent of Contractors. However, even within this group, there are Contractors with ratios under the state average that would receive additional funds. There are also a small number of Contractors in the lowest quartile who have ratios above the state average and who would receive a negative adjustment.

Ratio of Participation to Certifications

This factor recognizes that agencies with a greater turnover in caseload than other agencies incur more cost per participant. For this factor, each Contractor's total participation for nine months of the current year is divided by the number of certifications (and recertification)s performed during the same period to produce a ratio. (For the table in Appendix E, authorized caseloads in Column D were used, as the nine-month participation figure was not readily available. Correspondingly, the estimated number of certifications in Column U is an annualized figure instead of a nine-month figure. This factor should use a combination of new certifications and recertifications. For this study, only new certifications were available. Total annual certifications and recertifications were estimated for Column U by multiplying the number of new certifications per month in Column T by 36 (i.e., using a 3 to 1 ratio of new to recertifications times 12 months).

Next, the caseload and certification columns are totaled and the statewide ratio of participation to certifications is determined (bottom of column V). Each Contractor's ratio is compared to this statewide ratio. Contractors with a ratio lower than the average have a greater turnover and thus a greater cost. For each percentage point that a Contractor's ratio is lower than the statewide average it receives one tenth of a percent of the base rate. For each percentage point it is above the state average it loses one tenth of a percent of the base rate. The percentage differences are shown in Column W and the results of the calculations are shown in Column X.

The base rate per participant (and the adjusted base rate as well) is applied to "participation," which is the number of people who actually receive food instruments for a given month. However, this rate pays for a wide variety of activities in addition to issuing food instruments, activities such as certifying and recertifying participants. It is much more time consuming and expensive to perform a certification than simply to issue food instruments to a participant. If all Contractors have the same ratio of participation to certifications this would not matter. However, some Contractors by their nature tend to perform a higher ratio of certifications. For example, these may be hospital-based programs that certify infants and new mothers who return to other clinics, or they may be urban Contractors with a more mobile population. This factor compensates them for the difference in composition of their workload.

Geographic Area

The final adjustment factor is geographic area served, defined as the number of counties in which a Contractor has clinic sites. Most Contractors currently serve only a single county. Those Contractors that serve multiple counties incur greater overall travel costs, both for actual mileage and for “non-productive” employee time spent in travel, putting them at a financial disadvantage relative to other Contractors. As the Department shifts to fewer, regional Contractors, this issue will take on greater importance.

For each county greater than one that a Contractor serves, it receives a one-tenth of a percent point of the base rate per additional county. So, for example, a Contractor serving three counties would receive an adjustment of two-tenths of a percent. Column Y shows the number of counties served by each Contractor. Column Z shows the percentage adjustment the agency receives, and Column AA shows the amount of the adjustment.

In some of the Local Contractor visits, staff described their service area as including several counties because they have participants who reside in other counties. State policy allows any Contractor to serve a resident of any county. However, out of county residence affects the participant’s cost in getting services, not the Contractor’s cost in providing them. So, the operational definition for this factor is the number of counties in which the Contractor has WIC clinics.

As an alternate approach to this factor the state could begin collecting detailed information on the mileage between each Contractor’s home office and each of their clinic sites. This could either be multiplied by an actual mileage reimbursement amount, or Contractors total mileage could be indexed against a statewide average, as in the other factors. Contractors serving multiple sites within a single county might or might not have more mileage cost than those Contractors with a single site, but it would depend on whether staff were dedicated to a single site or whether they traveled between sites. To be equitable, this distinction would have to be identified. A separate calculation would have to be made if the methodology were to also account for lost staff time.

In either approach, the Contractors that would stand out from the rest and receive additional funds from this factor would still be those serving multiple counties. The use of counties greatly simplifies the administrative requirements for both the state and Local Contractors in calculating this factor.

Illustration of Methodology

If this methodology were adopted, a spreadsheet would be used to automatically calculate all the variables for all Contractors. To illustrate this approach, a sample worksheet was developed using the current 119 Contractors. This worksheet is shown in Appendix E. As explained in alternative one, the ending base grant per participant for FFY’2001 was \$7.79. This was used as the base grant for the first version of this worksheet. A second version was developed using \$8.17 as the base rate. This is the rate that could have been used in FFY’2001 to allocate an amount including the unused funds (excluding spendforward funds).

Columns EE through LL of Appendix E provide an analysis of the components of the methodology. Columns EE through HH show the effects of the adjustment for bands by individual agency as well as by quartile of agencies (based on size). Columns II through LL show the effects of the adjustment factors by individual agency as well as by quartile of agencies (based on size). The following table (Table 14) summarize the overall effects of this alternative using both rates.

Table 14—Overall Effects of Alternative Two

	Base Grants	Final Grant Amounts	Change Due To Band Adjustment	Change From Adjustment Factors	Total Change
All 119 Contractors @ \$7.79	\$11,825,212	\$11,906,846	\$297,984	(\$216,350)	\$81,634
<i>1st Quartile</i>			(\$175,596)	(\$3,164)	(\$178,760)
<i>2nd Quartile</i>			\$211,100	(\$117,158)	(\$93,942)
<i>3rd Quartile</i>			\$167,756	\$65,887	\$101,869
<i>4th Quartile</i>			\$94,724	\$30,141	\$64,583
All 119 Contractors @ \$8.17	\$12,402,052	\$12,489,770	\$312,520	(\$224,802)	\$87,718
<i>1st Quartile</i>			(\$184,162)	(\$3,318)	(\$187,480)
<i>2nd Quartile</i>			\$221,397	(\$122,873)	\$98,524
<i>3rd Quartile</i>			\$175,939	(\$69,101)	\$106,838
<i>4th Quartile</i>			\$99,345	(\$29,509)	\$69,836

Using the \$7.79 rate per participant, the total amount of funds allocated under the final adjusted grants was \$81,634 more than the base grant (an increase of .7%). In the version that uses \$8.17 as a base, the total allocated is \$87,718 more than the base (again, an increase of less than one percent). In alternative one, the bands were set as a level that resulted in allocating approximately the same amount through the bands as in the base grants. In this alternative, the net total of the other adjustments is a negative amount. In order to allocate the full amount of funds available, the percentages for the bands were adjusted slightly so that the net increase in the funds allocated through the bands is comparable to the net decrease through the other factors.

This spreadsheet illustrates the overall effect of this alternative. Through the bands adjustment, funds are shifted from the largest one fourth of the Contractors to the remaining ones. Through the other adjustment factors, funds are shifted between agencies, but the effect does not fall predominantly on any particular size of agency. For example, after the band adjustment, the factor with the greatest effect is the salary differential, which can affect both large and small agencies. . There is a net decrease in funds from these factors for all quartiles of agencies. For the largest quartile, there is a net decrease in total funds compared to the base. For the remaining three quartiles, there is a net increase in total funds compared to the base.

V.8.2. Costs, Benefits, and Limitations of Methodology

As with Alternative One, the overall cost to the Department of using this funding methodology should not be inherently different than the overall cost of the current methodology. The services to be provided by Local Contractors do not vary based on the allocation process. This methodology distributes the same amount of funds to meet the same requirements, but in different proportions. Both the current methodology and this alternative should allocate all available funds to Local Contractors. As long as the average statewide grant per participant is recalculated as the first step of the allocation process each year, that will be the outcome.

The primary benefit of this methodology is that it attempts to more closely align funding with unavoidable differences in cost between Contractors. It recognizes that size and the resulting economies of scale are a big driver in the cost per participant, but that other factors cannot equitably be ignored. Most of the individual factors do not try to reflect actual documented cost differences. Instead they are surrogate measures; they are easily identifiable, measurable, have available data, and direct a “reasonable” amount of funds to individual Contractors based on that factor. For the most part, the factors are relatively difficult for individual Contractors to manipulate to their advantage.

One limitation of this approach is that the factors described are not the only cost factors that could be considered in the methodology. The more factors that are included, the more opportunity it provides for someone to suggest additional factors to consider. For example, the caseload turnover factor addresses the additional staff time required as a result, but one could make the argument that high risk participants also require more time and should be a factor. Personnel costs are used as a factor, but not overall cost of living differences that could affect things such as the cost of rent and utilities. There may be inherent differences in cost for different types of Contractors – hospitals versus county health departments versus community health centers – but the project was not able to identify or quantify these. Some may argue that certain factors partially duplicate or overlap the effect of other factors.

Once agreement is reached on which factors should be used, there may still be disagreement over the relative weight to give to each factor. As described, the bands have the largest effect on the grant per participant. But some might argue that salary differences between counties have a greater effect on cost of operation than caseload size.

The relative weights of each factor can be adjusted to achieved the right balance once the Department decides to use this approach, without affecting the overall structure of this methodology.

V.8.3. Detailed Implementation/Transition Requirements

As with the first alternative, the implementation process will depend to some extent on the level of funding available. If enough additional funds are available to accomplish the transition to the new methodology without major reductions in funding (i.e., more than about 5-7%) for any single Contractor, this approach could be implemented all at once. If the funding is not sufficient for this, a maximum allowable amount of decrease should be defined. Once the amount of money necessary to make up the shortfall resulting from this cap is calculated, a corresponding ceiling can be established on the maximum amount of increase that can be funded. The ceiling should be set at a level to provide the correct amount of funds, not necessarily at the same percentage basis. For example, there may be a 7% cap on reductions which requires a 10% cap on increases.

A spreadsheet file can be developed to run this methodology automatically. (The electronic version of Appendix E would provide a good basis). Once established, it will be fairly easy to update with a new grant per participant base amount each year. The national appropriation amount, estimated Missouri share of NSA funds, state agency budget total, amount available for Local Contractors, estimated Missouri share of food funds, average food package cost, statewide initial authorized caseload, and available administrative grant per participant can all be built into the same spreadsheet. As the estimate of national funding is updated, all the other calculations can occur automatically, resulting in a new base grant per participant for the methodology.

V.9. ALTERNATIVE THREE

V.9.1. Description of Methodology

Alternative Three resembles alternative two in that it allocates funds on a grant per participant basis, uses caseload bands to adjust the rate upwards for smaller agencies and downwards for larger agencies, and factors in regional differences in average salary costs. However, it does not include any of the other adjustment factors found in alternative two. Appendix F contains an illustration of this approach. In the following description, the column letters refer to this appendix.

Methodological Process

The Department first determines the total amount of funds to be allocated to Contractors through this methodology. The Department calculates the statewide average Administrative Grant per Participant by dividing this amount by the authorized caseload (Column D). Next, Contractors are assigned to one of the five bands presented in alternative one (Column E). Agencies in the smallest band (one) receive an adjusted base grant per participant up to 15% above the statewide average. Agencies in the largest band receive an adjusted base grant per participant up to 10% lower than the statewide average. The actual percentages used for each band may vary slightly from year to year depending on the number of agencies that fall into each band.

Next, the Department calculates the salary differential for each agency. The average (mean) annual registered nurses salary (Column I) for the region in which the Contractor's home office is located is compared to the statewide average. The percentage difference from the statewide average is shown in column K.

For each one percent that the regional mean salary is higher or lower than the statewide mean salary (Column K), the Contractor receives an increase or decrease equal to one half percent of the base grant (Columns C).

The salary adjustment (Column L) is added to or subtracted from the adjusted base grant to produce the Final Grant Per Participant for each Contractor (Column M). This is multiplied times their authorized caseload level (Column D) to provide their Final Grant Amount.

Illustration of Methodology

The table in Appendix F illustrates how this alternative would work with the current 119 Contractors using the same two Base Grant per Participant amounts as in the first two alternatives (\$7.79 and \$8.17).

Columns O through W of the appendix show the outcomes of the methodology. Columns O through R show the effects of the adjustment for bands by individual agency and by quartile of agencies (based on size), while Columns S through V show the effects of the salary adjustment. The following table (Table 15) summarize the overall effects of this alternative using both rates.

Table 15—Overall Effects of Alternative Three

	Base Grants	Final Grant Amounts	Change Due To Band Adjustment	Change Due To Salary Adjustment	Total Change
All 119 Contractors @ \$7.79	\$11,825,212	\$11,938,637	\$263,323	(\$149,899)	\$113,424
<i>1st Quartile</i>			(\$215,118)	\$55,446	(\$159,671)
<i>2nd Quartile</i>			\$211,100	(\$96,810)	\$114,289
<i>3rd Quartile</i>			\$172,617	(\$75,819)	\$96,798
<i>4th Quartile</i>			\$94,724	(\$32,716)	\$62,008
All 119 Contractors @ \$8.17	\$12,402,052	\$12,521,009	\$276,168	(\$157,211)	\$118,957
<i>1st Quartile</i>			(\$225,611)	\$58,151	(\$167,460)
<i>2nd Quartile</i>			\$221,397	(\$101,533)	\$119,864
<i>3rd Quartile</i>			\$181,037	(\$79,517)	\$101,520
<i>4th Quartile</i>			\$99,345	(\$34,312)	\$65,033

To facilitate comparison, this example used the same percentages for the bands as used in Alternative Two. One result is that in both versions of this methodology (the one using \$7.79 as the base and the one using \$8.17 as the base) the amount of funds allocated through the two adjustments is just over \$100,000 higher than the target amount from the base grants. This relatively minor difference could be reduced by changing the percentages used for the three smallest bands from 115% to 113%, from 110% to 108%, and from 105% to 104%.

V.9.2. Costs, Benefits, and Limitations of Methodology

As with the previous alternatives, the total allocated through this funding methodology is the same as the total allocated through the current methodology. The services to be provided by Contractors are the same, although some Contractors will have additional funds to use and others will have fewer funds with which to meet the requirements. Any of the methodologies will allocate all available funds to Local Contractors. The key is in recalculating the average statewide grant per participant at the beginning of the allocation process each year.

This methodology recognizes the two largest cost drivers in local service delivery: the economies of scale that accrue to large agencies, allowing them to operate with a lower administrative cost per participant, and the unavoidable regional differences in the one cost - personnel – that comprises the vast majority of the total cost. It does not try to identify, quantify, and balance all of the other individual factors that have an influence on cost of operation. Some of the other differences are relatively easy to identify (e.g., those used in alternative two) while other are not. For those that can be identified, it is difficult to determine the exact financial impact. Consequently, approaches that use these factors estimate a “reasonable” amount to allocate based on these factors. States that use multiple factors generally work through a consensus building process to determine the items that all parties can agree on and the weight to give them. This alternative greatly simplifies this process.

This alternative is also easier to implement and use in an environment in which many of the Contractors may theoretically change from year to year. The data that is used is relatively independent of the particulars of the Contractor who will be serving an area. It does not depend on data reflecting past performance of the Contractor or management decisions a Contractor may make (such as how many clinic sites to operate).

The limitation of this approach is that it may not allocate funds quite as equitably as alternative two, because the cost impact of those other factors, however they are defined, is not considered. The approach is based on an implied assumption that all of the other cost factors balance each other out. In addition, the issue of salary adjustments becomes more complicated if the Department contracts with regional providers. If a majority of regional Contractors have staff that live and work in more than one county, rather than commuting from a central location, the approach for calculating the salary adjustment may need to be reconsidered. For example, the formula could be modified to allow multiple salary adjustments for a Contractor based on the proportion of total Contractor FTEs housed in different counties.

V.9.3. Detailed Implementation/Transition Requirements

The implementation requirements for this alternative would be similar to those for alternative two. Depending on total funding availability, it may or may not be necessary to cap the amount of increase or decrease for each Contractor.

V.10. ALTERNATIVE FOUR

V.10.1. Description of Methodology

The previous three methodologies reduce the allocation of funds to Local Contractors to mathematical formulas. The first methodology resembles formulas widely used across other states and USDA. The second methodology is similar to somewhat more sophisticated formulas used in a couple of other states (Colorado and Texas). The third strikes a balance between the first two regarding the amount of data used for the formula. This Fourth methodology takes a nod from another two other states (Massachusetts and Indiana), and bases the final grant amount on negotiation between the Department and the Contractors. Of these two states, Massachusetts, uses a sophisticated formula to arrive at an allocation figure for each agency. However, it uses this number as a starting point for negotiations with each Contractor. The other state forgoes a formula

altogether and simply negotiates a budget with each Contractor. The approach proposed for Missouri more closely resembles Massachusetts.

In this methodology, the Department first calculates the total amount of NSA funds available to allocate to Local Contractors through this methodology and the amount of caseload to authorize. The Department withholds a small percent (e.g. five percent) of the available Contractor funds, and uses the remainder to calculate the current year's average administrative grant per participant statewide. The average grant per participant is multiplied times each Contractor's authorized caseload and presented to each Contractor as the initial benchmark or target amount. Contractors then develop a budget in the amount they believe they need, whether this is above or below the target amount. A Contractor may request more than the target amount, but the budget must include a justification for any funds over that amount. State agency staff review each budget in the context of the overall Local Contractor Plan. Staff may tentatively approve budgets exceeding the target, drawing on the five percent reserve fund. Before any budgets are given final approval, the total amount requested is compared to the total amount available, including the reserve fund. If the total amount of funds requested statewide exceeds the amount available, Department staff negotiate appropriate budget reductions with each Contractor that is over their target amount. The Department will not reduce budgets across the board. Rather, the amount of reduction for any given Contractor will be based on negotiation and a common understanding between the Contractor and the Department of the Contractor's needs and priorities. If, after the initial round of negotiations, there are still too many funds requested, the SA will have the ultimate decision making power regarding the level of funding for each Contractor.

In this methodology, Local Contractors could still identify special projects in their LAP and request funding for them. The cost of the special projects would still be identified discretely in the budget; however, there would no longer be a distinction between the base grant and special project grants. They would be negotiated as a single budget. In the event the total funds requested exceed the amount available, the funding for special projects would be reduced first.

V.10.2. Costs, Benefits, and Limitations of Methodology

As with the first three alternatives, the amount of funds allocated to Local Contractors based on this methodology would be the same as is currently allocated. However, the administrative responsibility for Department staff would be increased due to the negotiation process for each Contractor. Since the number of Department staff available for this process is fixed, there would not be a corresponding increase in cost. However, other activities would of necessity have to give way during the period of time staff spend reviewing and negotiating LAPs and budgets.

With each of the first three methodologies presented, there was an acknowledgement of the imperfections in the formulas and the data used in them. They are an attempt to allocate funds in a manner reasonably close to a fair and equitable distribution. The fourth methodology is based on the premise that any formula is inherently unable to accurately or adequately account for all legitimate differences between Contractors in the cost of doing business. Formulas cannot – and are specifically designed not to – recognize special circumstances in an individual Contractor that affect their costs. This methodology is based on the assumption that professional judgment by people intimately familiar with a Contractor's operation can make better, more informed decisions than a

formula. It uses a mathematical approach to provide a rough distribution of funds as a starting point or benchmark, and then allows professional decision making to fine-tune it.

This methodology also recognizes that, human nature and the level of WIC funding being what it is, Contractors will tend to ask for as much as they believe they need and can get approved. It also recognizes that this is likely to add up to more than the amount the SA has available. Consequently, to make this approach feasible, when calculating how much is available to distribute, the Department keeps some funds in reserve. The amount of this reserve is not shared with the Local Contractors, to avoid the temptation by Contractors to include their presumed share of the reserve in their budgets when calculating their requests.

The single biggest current limitation of this methodology is the number of Local Contractors in Missouri. While the individual budget negotiations in this approach are likely to be successful, they would require a significant amount of staff time to conduct. However, as Missouri moves to consolidate the number of agencies it contracts with, this current limitation will diminish and this approach will begin to have certain advantages compared to the other three alternatives. For example, changing to a new set of Contractors introduces a number of unknowns to the cost of providing local services. There may be costs associated with moving clinics, retrofitting facilities, hiring and training new staff, purchasing equipment, and educating participants about changes in service hours and locations. Formula based allocation methodologies do not take these special costs into account very well. It would still be possible to fund all of these costs through special grants in a formula based approach, but the result would be more administrative work for the Department. In this methodology, all the costs could be included in a single grant amount. The other two alternatives, especially the second one, require collection and analysis of data from the Local Contractors. This requirement is quite feasible when the population of Contractors is stable from year to year. However, it becomes more difficult in a competitive environment where some of the applicant agencies may not have provided services previously and the data used for the formula is different depending on what agency is being evaluated.

The discussion to this point has treated this alternative as mutually exclusive from the first three methodologies. However, the Department could implement a hybrid of this alternative with either of the first three methodologies. For example, the Department could use the bands identified in Alternative One to determine the initial benchmark amounts for each Contractor, rather than using a single grant per participant amount. This could arguably provide a more equitable starting point for any negotiations.

The Department could also use the approaches in alternatives two or three to provide the initial target amounts. However, as described earlier, alternative two is more difficult with a shifting pool of Contractors. Alternative three would not be as difficult, as long as the regions to be served were consistent from year to year. Massachusetts uses a complex formula to provide starting amounts, and then negotiates final budgets from there. However, even though they have a competitive grant application process in theory, they typically receive only one application for each of their designated service areas.

If Missouri anticipates a truly competitive process with multiple applications for each area, it would be more feasible to combine alternative four with alternative one than with alternative two, and probably more feasible than with alternative three.

V.10.3. Detailed Implementation/Transition Requirements

Since this approach does not start with the presumption that any single Contractor or group of Contractors will face a reduction in funding, it does not require a transition period like the other two alternatives. However, because of the time required to conduct the negotiations, it will probably be necessary to begin the process about a month earlier in the year than is done currently.

VI. PROCUREMENT PROCESS

VI.1. CURRENT LOCAL CONTRACTOR POOL

The federal USDA WIC regulations at 7CFR246. define a Local WIC Contractor as “A public or private, nonprofit health or human service agency which provides health services, either directly or through contract, in accordance with 246.5.” Only government Contractors and private, not-for-profit Contractors are eligible; for-profit entities of any sort cannot be Local WIC Contractors.

Missouri currently has one hundred and nineteen (119) Local Contractors, a number that has remained relatively stable for several years. The vast majority of these Contractors are county public health agencies, with the remainder divided between city health agencies, hospitals, private not-for-profit health clinics (community health centers, FQHCs, etc.) and community action programs. The number of each is as follows:

County Public Health Departments:	101
City (or combined city/county) Health Departments:	4
Hospitals	3
Not-for-profit health clinics	8
Community Action Agencies	3

One requirement of this project was to “provide recommendations on a procurement process to assure that every geographic area of the state will be served.” Since all counties in the state currently have at least one WIC service provider, the objective of this task was to identify any changes in the current procurement process or strategy that would improve the quality of services, increase administrative efficiency, or reduce administrative cost without negatively affecting the availability of services anywhere in the state.

VI.2. HISTORICAL PERSPECTIVE ON SELECTION OF LOCAL CONTRACTORS

The original federal regulations, written in the early 1970’s, established a priority system for the selection of new Local Contractors as a state expanded the program into unserved areas. The priority system is still in regulations and may also be used by a state agency when the state has competing applications for service and has to choose between two Local Contractors. The priority system establishes five levels. Each level refers to a “public or private nonprofit health agency.” No priority is given to either government or private Contractors. The differences in priority have to do with the provision of health services to participants. Those Contractors that “...provide ongoing, routine pediatric and obstetric care and administrative services” themselves get first priority, followed in order by those that contract with another agency for these services, those that contract with private physicians to serve special populations, those that contract with private physicians in general, and those that simply provide referrals to private physicians for these services.

When the WIC Program was young, small, and relatively unknown, states encountered a variety of reactions when attempting to add new Local Contractors and expand services. In a few areas potential Local Contractors eagerly submitted applications when offered the opportunity and the states had to apply the priority system and their own evaluation criteria in deciding which ones to

approve. Just as often, however, state agencies had to seek out Local Contractors to apply for services so they could expand. In some localities, and even entire states, these efforts with met with reactions ranging from indifference to resistance or open hostility. WIC was new, unproven, and misunderstood, and it did not enjoy the reputation for effectiveness that it has subsequently earned.

In most states, the state agency ended up with the particular types of agencies it contracted with because that was what was available. In many northeast states, county health departments were small, not very well developed, and not used to providing direct services. Consequently, these states contracted with a lot of community action agencies to operate the WIC program. As one moves further west, county health departments tended to be more organized and more states contracted with them for WIC, although the pattern is not consistent. Two other states in the same USDA region as Missouri – Kansas and Colorado – both have strong county health department systems and use them as Contractors for WIC. Missouri's immediate neighbor to the north, Iowa, is an exception and contracts primarily with Community Action Agencies.

One effect of this difference in type of Local Contractor is reflected in the number of Local Contractors that states contract with. Colorado has forty-one Local Contractors to serve its sixty-three counties. The public health departments primarily serve single counties while the five private non-profit agencies serve multiple counties. Iowa has only twenty agencies to serve ninety-nine counties. The two county health departments they contract with serve single counties, while the community action agencies serve from three to ten counties each. The difference in these two states is due primarily to the predefined service area of the Local Contractors when they first contracted with the WIC Program, rather than to anything specific that the states did.

In Missouri, WIC services have historically been provided by county or regional public health departments in large areas of the state. In the 1970s and early 1980s regional public health departments provided services in several areas. As county public health departments were formed in Southeast Missouri during the late 1980s, many of them applied to become WIC providers, and the number of WIC Contractors in that region tripled (from eight to twenty five).

In more populated areas such as St. Louis and Kansas City, where there are also more providers of health services, the state began contracting with multiple WIC providers in the 1990s. Like most other states, Missouri to date has not made a concerted effort to identify other providers. As long as the existing base of providers was able to meet the demand for services and provide an acceptable quality of service, there was no particular reason to look elsewhere. However, the Department has agreed to add new Contractors as agencies such as Federally Qualified Health Centers (FQHCs) opened up and asked to become providers. During the 1980s, and especially the 1990s, the trend in public health departments has been to discontinue providing direct maternal and pediatric health care services. Many public health departments no longer provide any health care services to WIC populations other than immunization clinics. FQHCs, on the other hand, do provide these services so they, and the Department, saw WIC as a natural complement to their mission. The FQHCs that were visited for this project reinforced the idea that providing WIC helped them fulfill their mission.

The net result of this activity over the last thirty years is that Missouri has ended up with more Local WIC Contractors than any other state. There is no evidence to demonstrate that the quality of services has suffered as a result. However, the current arrangement requires a considerable

administrative effort by the Department to provide the oversight and management role required of it by federal WIC regulations. It is expensive to operate and maintain all of the small, separate Local Contractors across the state. Much of the focus of the alternative funding methodologies is on shifting funds from larger agencies to smaller agencies, to cope with their inherently higher administrative cost per participant. The need for this shift of funds might be diminished if there were fewer, larger regional WIC Contractors instead.

VI.2.1. Other States' Experiences in Competitive Bidding for WIC Contractors

One of the tasks of this study was to provide recommendations for implementing a new procurement process for Missouri WIC. The Department is interested in implementing a competitive bidding model for regional WIC Contractor in Missouri. Accordingly, BCA asked the other states interviewed about their procurement process. As described in Section III.7 of this report, there has been relatively little experience in other states with competitive bidding for WIC Contractors. Some of the reasons for this include:

- A lack of other suitable public or private Contractors capable of delivering services;
- A “closed process” in which the state routinely renews existing contracts for Local Contractors, with or without a new application, and does not solicit application from other Contractors;
- Political pressures by existing Contractors to maintain the “status quo;” and finally,
- A lack of interest by other Contractors due to the administrative cost of having a WIC Program. The phenomenon observed in Missouri of WIC grant funds being insufficient to cover the entire cost of delivering WIC services is not unique to this state. It has been a growing concern among all states for several years. A potential new Contractor may feel there is a benefit to its existing clients by being able to offer WIC along with its other services, but it would have to weigh the cost to its budget against that benefit.

There are two other salient factors that should be considered regarding the few states that have tried competitive bidding for Local WIC contracts in recent years. First, the competitive application process has more often been in conjunction with a set of programs or grant funds that a Contractor could apply for, rather than just for a WIC contract. The change has been part of a broader state health department strategic restructuring of local public health services. Second, putting WIC out for competitive bid has not guaranteed that there would actually be competing grant applications. More often than not, the only Contractor submitting a competitive application was the incumbent Contractor.

VI.2.2. Services Provided by Local Contractors

In Section V. of this report it was stated that the division of responsibilities between state agencies and Local Contractors is largely independent of the allocation methodology. The same is true of the procurement process. The Department defines the expectations for all Local Contractors. It has extensive policies and procedures which identify minimum staffing requirements, the types and quantities of nutrition education to be provided, and other quality standards. All Contractors are required to provide a standardized set of services and meet all the minimum requirements. The

services that can be provided and the costs that can be incurred are proscribed by both federal regulations and state policies.

VI.2.3. Recommendations for Missouri WIC Procurement Process

The Department of Health and Senior Services has expressed a policy intent to consolidate the number of WIC Contractors through some type of competitive procurement process. The administrative effort required for the Department to manage the contracts with the current 119 Local WIC Contractors is considerable, and the Department hopes to achieve a degree of administrative efficiency through this consolidation.

To accomplish the goal of reducing the overall number of contracts, it is quite possible the Department will have to replace the majority of the current Contractors. From the preceding discussion of other States' experiences, it should be clear that Missouri is heading into "uncharted waters." That is not to say that the Department should not move in this direction, but rather to point out that it will require careful planning and a comprehensive procurement strategy. There are a number of steps that should be included in the planning process, and two items that could be considered "pre-planning." These first two items are discussed in the following two sections.

VI.2.4. Define Objectives of the Competitive Procurement Process

The Department must first define the policy objective it is attempting to accomplish through implementing a competitive procurement process. Some common objectives of a competitive procurement are to:

- purchase the same goods or services at a reduced price; or purchase more of the goods or services for the same price;
- purchase goods or services of a higher quality for the same price; or,
- reduce the administrative cost of purchasing goods or services or increase administrative efficiencies.

The applicability of each of these to the procurement of WIC services is examined below.

Issuing an RFP asking bidders to propose a cost for a WIC "unit of service" (participation), and then selecting a Local Contractor based on the lowest cost offered is probably not feasible. WIC has a finite amount of administrative funds available, which is not currently enough to pay for the entire cost of WIC services. Thus, unless bidders are told how much WIC can spend per participant, the costs proposed by bidders would likely exceed what is available. In purchasing WIC services using either the current allocation process or any of the alternatives discussed above the Department is stating what it is willing to pay for a unit of service, defined as "participation."

The Department defines the minimum participation required by a Contractor for their service area. Food funds are also a limiting factor, preventing Contractors from serving as many participants as they want. If additional food funds become available during the year, the Department may allow the Contractor to serve more than the authorized minimum caseload. Currently, there is an expectation by Contractors that in this event the authorized level will be increased and they will

receive additional administrative funds. If the Department instead states that it will not reimburse the Contractor for serving more than that number, it would in effect be getting more services for the same price. However, there would be no reason for Contractors to agree to do that.

The Department would also have difficulty using the ability to serve more participants as an evaluation factor in comparing competitive bids, since Contractors cannot definitively state in advance how many participants they can serve.

The Department's objective could be to get an improved quality of services through a competitive process. However, quality of service delivery in a WIC environment is difficult to demonstrate in a proposal. The Department would need to rely heavily on factors such as the type of organizational environment in an agency and the other health services to be provided with the Contractor's own funds. A potential Contractor could not get a competitive edge in an evaluation by offering to provide a broader range of services with grant funds than those that are mandated by the Department because, by definition, anything else is an unallowable use of WIC funds.

The last objective listed above is reducing the administrative cost associated with delivering services or increasing administrative efficiency. There is administrative cost at both the Department level and the Local Contractor level. The Department level administrative effort associated with reviewing and approving contracts will not necessarily be reduced by reducing contracts through a competitive process. In fact, if the effort is successful and the Department actually receives a number of competitive proposals, the administrative time required for reviewing these and selecting Local Contractors may actually be increased. However, in the long term, the time required for ongoing oversight of the Contractors should be diminished. For example, state health departments are required by federal regulations to conduct on-site monitoring of each Local Contractor at least once every two years. If the number of Contractors is reduced, the number of monitoring visits required goes down, although not proportionately.

Reduced administrative requirements at the Department level do not necessarily translate into reduced administrative cost, unless they are of such a drastic change that they result in a reduction in staff levels. Instead, they allow existing personnel resources to be re-directed to other activities designed to enhance program quality.

The administrative cost associated with WIC at the Contractor level is somewhat hidden, but is nonetheless real. The term "administrative grant per participant" is somewhat of a misnomer because the funds primarily pay for participant services cost. However, any reimbursable administrative costs that a Contractor incurs also come out of this figure. Common administrative expenses include such routine activities as documenting and reporting monthly administrative expenses, reviewing and approving timesheet, monitoring the budget, and corresponding with the Department. If the number of WIC Contractors is reduced, the statewide amount of time spend on these activities will be reduced proportionately. The same amount of funds may be spent at the Local Contractor level, but the net effect will be that the share of these funds spent on administration will be reduced and the amount spent providing participant services or on program development and enhancement will be increased. Larger agencies may find it easier to recruit and retain qualified staff. Over the long term, this will all be to the benefit of the WIC population.

VI.2.5. Establish Underlying Principles

Just as the first step in adopting a new funding methodology is to establish underlying principles, this should also be one of the first steps in developing a new procurement approach. These principles should define the acceptable parameters for change as well as establish the desired outcomes. For example, the principles may include all or some of the following:

- There should be a minimum size of Local Contractor. Minimum size could be defined by either geographic area served or authorized caseload, or both.
- There should continue to be a minimum of one WIC clinic site in each county, including rural counties. Alternately, the Department could establish a maximum amount of participant travel time to a clinic site from any point in the Contractor's defined service area.
- Consolidation of Contractors should not result in a reduction in the current number of clinic sites.
- Consolidation of Contractor contracts should result in a net reduction in administrative effort for the Department.
- Priority should be given to Contractors who provide WIC services in the context of comprehensive health care. In other words, the federally defined priority system would be used and those Contractors that provide other health services themselves would receive priority over Contractors that have to refer participants to other providers for health services. (While this may seem obvious on its face, it is actually a fairly complex issue. WIC has now had thirty years experience in delivering services in all types of environments. In spite of an extensive track record of positive evaluations, little is known about the relative effectiveness of WIC based on the in-house availability of health services compared to a referral approach.)

VI.2.6. Determine WIC's Long Term Relationship With Other DHSS Programs

If DHSS desires to consolidate the number of WIC contracts, it must decide whether it will do this unilaterally, or as part of a DHSS effort to consolidate Contractors and funnel a package of related grant funds to selected Contractors. There are advantages and disadvantages to both approaches. Combining programs in a single grant application may provide a somewhat more attractive package for Contractors to bid on. Conversely, it may limit the pool of potential Contractors who would be interested. A consolidated approach would also require more time to plan and implement. Since WIC's requirements for Local Contractors are so extensive, and since many of these are federally mandated and thus not subject to change, it would require extensive planning to develop a consolidated application process that multiple programs could agree on. Weighing all of these factors, we believe it is probably more feasible for WIC to proceed on its own with a restructuring of its Contractor base.

VI.2.7. Identify the Target Pool of Contractors for Consolidated Contracts

DHSS could reduce the number of Contractors it contracts with two ways. First, in areas where there are multiple Contractors, such as St. Louis and Kansas City, it could decide to allow only one Contractor to serve the area. Second, it could require Contractors to cover larger service areas (i.e., multiple counties).

Federal regulations allow states to contract with multiple Contractors in an area when they deem it necessary to insure adequate access to services. Like Missouri, most states with densely populated urban areas contract with multiple Contractors in those areas. Missouri has not always had the number of Contractors in urban areas that it does now. Contractors have been added over time as a need has been determined or as Contractors serving special populations have made a request of the department. During this project, all or most of the Contractors in large urban areas were visited. The information gathered during these visits did not indicate that there is an excess of Contractors in these areas. Some Contractors expressed a desire for DHSS to more actively coordinate the placement of new clinic sites, to increase the likelihood that they would target unserved populations rather than just produce shifts between Contractors. However, it is not certain that consolidating the number of Contractors in these counties would improve access to services or reduce overall administrative costs.

The biggest potential gain in efficiency could come from consolidating Contractors in rural areas. Small Contractors have the same administrative requirements as large Contractors, but have fewer participants over which to amortize those costs. Consequently, a larger portion of the administrative grant per participant is needed for administration (e.g., planning, self-monitoring, outreach, etc.). Theoretically, if a single Contractor can be found to serve several sparsely populated rural counties, they should be able to do it more cost effectively because these functions are performed only once instead of repeated for each separate county.

BCA believes it is unlikely that very many of the current county health departments would be willing to take on the responsibility for operating clinics in other counties, particularly if the reimbursement was not enough to cover the entire cost. Most of them do not define delivery of services in other counties as being within their agency's mission. Fortunately, there are other alternatives. For example, several county health departments could form a coalition, with one county agreeing to manage the WIC contract with DHSS and subcontracting with the other counties.

Another alternative for creating larger service areas is to find different Contractors to apply for the contracts. There may well be Contractors in various parts of the state that would be interested in this, such as community action agencies that already provide Head Start in multi-county areas or Federally Qualified Health Centers (FQHCs) that draw clients from multiple counties.

Attached to this report as Appendix G-1 is a list of Community Action Agencies and a map showing their coverage of the state. Appendix G-2 is a similar list and map of Federally Qualified Health Centers (FQHCs).

VI.2.8. Start With Realistic Expectations

The goal of this recommendation is to insure that as the Department modifies its procurement process it approaches this task realistically. It is important for the Department to test its assumptions before committing to a course of action.

The first assumption that should be tested is that there are a sufficient number of alternate agencies in all parts of the state who are willing to apply for regional WIC contracts. One way of testing this assumption is to develop and release a Request For Information (RFI) prior to issuing a Request for

Proposals (RFP). An RFI is similar to an RFP in structure. However, rather than requesting specific proposals in which Contractors would commit to providing services in exchange for funding, an RFI solicits information with which to gauge the level of interest in providing services. It is a vehicle which could help the state identify the universe of viable alternative Contractors interested in providing WIC services. The same document could be used to answer the question of whether county health departments would be willing to expand their service areas.

To implement regional contracts, the Department will need to either leave it to bidders to propose service areas or define the regions itself. If the Department leaves it to bidders to propose areas, it runs the risk of having proposals for overlapping or unserved areas. However, to define regions, some research will be necessary to determine what areas are reasonable. An RFI would also assist in this task.

The results of the RFI would also help the Department identify the most appropriate approach for implementing competitive regional contracts. The RFI may show that it is feasible to implement this approach statewide at one time. Conversely, it may also show that a phased-in implementation is more likely to be successful.

VII. FINAL REPORT SUMMARY, CLOSING, NEXT STEPS

VII.1. FUNDS ALLOCATION METHODOLOGY

Prior to implementing any of the alternatives described in this report, BCA recommends that the Department share this report with their current Local Contractors and actively seek their response and recommendations regarding the funds allocation process. The Department has the responsibility to decide what approach to implement and does not necessarily need the concurrence of the Contractors. However, the Local Contractors are likely to have valuable insights which will improve the final methodology. As part of this process, the Department should identify the principles and priorities for changing the funding methodology. Other states have spent from a minimum of six months to three years in this process. If the Department begins this process within the next month or two, it would be a reasonable goal to have the new methodology in place to use in allocating FFY'2004 funds.

As a final recommendation for the funding methodology, BCA recommends that some type of small, permanent state agency/Local Contractor stakeholder group be identified to monitor the performance of the new methodology and advise the state on the minor revisions to the process that are inevitable. Just as WIC funding is not static from year to the next, neither are good WIC funding methodologies.

VII.2. PROCUREMENT

The previous section recommended development of an RFI as a first step in exploring alternate procurement strategies. In conjunction with the development of this document, the Department should advise the existing Local Contractors of the long-term goals for this initiative, why it is necessary to move in this direction, and what the initial steps will be. Change, by its nature, is often threatening to people. It should be expected that there would be some level of apprehension among members of these groups, as some will feel their programs are threatened. It is critical that this process not result in a disruption of WIC services anywhere in the state. Openness about the goals and the process and ongoing communication with the Local Contractors will help reduce tensions and apprehension.

APPENDIX A EXPENDITURES OF CONTRACT FUNDS FOR FY1999-2001

See Electronic Excel Spreadsheets

**APPENDIX B
SUMMARY OF WIC ALLOWABLE COSTS
(USDA WIC REGULATIONS AND OMB CIRCULARS)**

Federal WIC Regulations

Federal Regulations at 7CFR246 govern the WIC Program. Section 246.13, Financial Management System, set out USDA's rules regarding the types of accounting controls, records or expenditures, and cash management procedures states must maintain. Subsection 246.13(j) requires the State agency to "ensure that all local agencies develop and implement a financial management system consistent with requirements prescribed by FNS and the State agency..."

Section 246.14, Program Costs, defines the types of costs that are allowable with WIC Program funds. First, the regulations specify that there are two types of costs, "food costs" and "nutrition services and administration" (NSA) costs. In general, according to the regulations, all costs necessary to operate the program and meet the program's objectives are considered allowable costs.

Food costs can be used only for the purchase of supplemental foods or for the purchase and rental of breast pumps. Under certain circumstances related to increased program participation a State agency can, with FNS approval, "convert" food funds into NSA funds. The state may get this approval, referred to as "conversion authority" in one of two ways. It may submit a plan to FNS to reduce average food cost per participant and increase participation. If the plan is approved, the state may convert the amount of funds specified in the plan. The other, more common, approach is to actually serve more participants during a year than the projected amount on which the FNS funding formula is based. The state earns conversion authority equal to the Administrative Grant per Participant (AGP) rate in the current federal allocation formula times the participation in excess of the projected amount. However, the state can only use this conversion authority to the extent that it has administrative expenses in excess of its NSA grant for the year and uses the converted funds to pay for them. In other words, a State may earn more conversion authority than it is able to exercise.

In addition to paying for operation expenses, a State may use NSA funds to pay for food costs without prior approval by FNS. There are two types of NSA costs, direct and indirect costs. Both direct and indirect costs must be allowable under federal regulations at 7CFR3016, the Uniform Requirements for Grants and Cooperative Agreements to State and Local Governments. Subsection 3016.22 of those regulations state that costs must conform to the applicable cost principles described in OMB Circular A-87 or A-122, depending on the type of agency spending the funds. (These cost principles are described below following the discussion of the WIC regulations.) Indirect costs must also be supported by an approved cost allocation plan. The only other restriction placed on indirect costs is that food costs may not be used in calculating the base for the indirect rate.

The regulations specifically identify several categories of approved direct costs. These include:

- Nutrition education and breastfeeding promotion and support. In addition, there are required minimum amounts that must be spent on each of these two categories.
- Program certification, nutrition assessment, and procedures and equipment used to determine nutritional risk.
- Outreach services.
- Administration of the food delivery system.

- Translators and interpreters
- Fair hearing costs.
- Transportation of rural participants by local agencies, with prior approval from the State agency.
- Monitoring of program activities (e.g. such as state agency reviews of local agencies)
- Personnel costs for screening for drug and other substance use and making referrals. (However, the cost of laboratory tests is not allowable.)
- Breastfeeding aids to support initiation and continuation of breastfeeding.

The regulations describe some of these categories in detail, particularly the nutrition education and breastfeeding items, since they have spending requirements associated with them. Other categories, such as outreach or the administration of the food delivery system, have no explanation and allow for considerable state agency discretion.

The regulations also specify three types of costs for which a state must get prior approval from FNS. These are automated information systems, capital expenditures over \$2,500., and contracted management studies.

In summary, if an expense is of a type not specifically disallowed by OMB Circulars A-87 or A-122, and if it can reasonably be considered to fit one of the categories listed above, it is probably an allowable cost.

OMB Circulars

The federal Office of Management and Budget (OMB) publishes guidance for the spending of federal funds in the form of Circulars. OMB Circular A-87 describes cost principles to be followed by grantees of federal funds who are State, local or Indian tribal governments. Circular A-122 is the comparable document for private nonprofit organizations other than an institutions of higher education or hospitals.

The Circulars contain general principles for determining allowable costs, such as the stipulations that costs must “Be necessary and reasonable for proper and efficient performance and administration of Federal awards” and that they must “Be authorized or not prohibited under State or local laws or regulations.” Reasonable costs are further defined as those that “...in nature and amount do not exceed that which would be incurred by a prudent person under the circumstances prevailing at the time the decision was made to incur the cost.” In other words, the question of reasonableness can be subject to interpretation. Costs may be allowable in some circumstances and not in others; for example, advertising and public relations. The circular defines the appropriate uses for these and declares all other advertising and public relations costs to be unallowable.

Costs may be either direct or indirect, as explained further below. For the most part, the issue of whether an item is an allowable cost is separate and independent from whether it is charged as a direct or indirect cost. Some conditional costs such as those described above also contain restrictions regarding their treatment as direct or indirect cost; however, these are the exception

rather than the rule. The Circular states that “There is no universal rule for classifying certain costs as either direct or indirect under every accounting system. However, another basic stipulation related to the distinction between direct and indirect cost is that they must “Be accorded consistent treatment. A cost may not be assigned to a Federal award as a direct cost if any other cost incurred for the same purpose in like circumstances has been allocated to the federal award as an indirect cost.” In other words, if a cost is treated as an indirect cost for one purpose, a similar cost may not be charged to a federal grant as a direct cost.

In general, direct costs are those that can be identified specifically with a particular objective, while indirect costs are those incurred for a joint purpose benefiting more than one objective. In addition, indirect costs are the type that are difficult to break out and assign to individual objectives without a disproportionate effort.

Costs may be allocated through an indirect rate based on a cost allocation plan. Costs may also be allocated through an allocation plan but without using an indirect rate. In other words, an agency can have a cost allocation plan without developing an indirect rate, but cannot develop an indirect rate without first developing a cost allocation plan.

An indirect rate is an accounting device used to determine in a reasonable manner the proportion of shared costs that each program in an agency should bear. It is a percentage calculated by dividing the total costs to be included in the indirect cost pool by the total costs in the base. The base is typically total salaries, total personnel costs, or total direct costs. To apply the indirect rate to a particular program, the percentage is multiplied times the program’s share of the base cost. There are different types of indirect rates (predetermined, fixed, provision, final, etc.) which have to do with the process for calculating the rate and adjusting it from year to year. Some federal programs apply their own restrictions on the calculation or use of an indirect rate. For example, FNS does not allow WIC food costs to be included in the base for determining the rate, as this would disproportionately shift costs to the WIC Program.

If an agency wants to use an indirect rate, it must be approved by a cognizant federal agency, which for human services agencies is typically the Department of Health and Human Services. The agency’s indirect cost rate proposal must include the proposed rate, agency financial data, worksheets and calculations including the allocation plan, organizational structure, and a certification by the agency’s chief official.

Agencies typically use the same indirect rate for all programs or activities. However, there are some circumstances in which an agency may have multiple rate. For example, a particular activity may require such a disproportionate share of administrative expenses (either high or low) that it is appropriate to identify a separate indirect cost pool for that activity. There are also situations in which a federal statute or grant award restricts the reimbursement of certain costs. The agency may be required to develop a “restricted rate” to exclude those costs.

Common types of allowable costs include accounting systems, advisory councils, audit services, data processing, bonding of employees, budget development, communications, personnel compensation, depreciation and use allowances (with some restrictions), employee health and welfare, equipment and capital expenditures, general government expenses (with some restrictions), insurance, maintenance and repair of facilities, materials and supplies, motor pools, professional

services, printing, property and equipment rental, some taxes, training, and travel. Many of these allowable costs have additional explanation, guidelines, restrictions, and exceptions to the restrictions.

Common types of unallowable costs include alcoholic beverages, contingency funds, contributions and donations, entertainment, fines and penalties resulting from violations of laws and regulations, fund raising, interest, and lobbying.

Implications for Local Contractors

It is relatively easy to compare the types of expenses normally charged to local WIC Contractors' grants with the federal WIC regulations and the OMB circulars to determine whether the costs are allowable. It is relatively rare to find direct costs charge to a WIC grant that are not allowable costs. Most of the grant funds are used for salaries of program staff and the remainder tend to be used for clinic and office supplies, travel, training, and equipment. All of these are clearly allowable.

Local contractors have a choice of charging WIC directly or indirectly for any general agency administrative costs. Under both WIC regulations and OMB circulars, these costs are clearly allowable. What becomes the most important factor for consideration is whether an agency that charges WIC for these costs (or shows them as an in-kind contribution) treats them the same way for WIC as for any of its other grant programs.

APPENDIX C STATE WIC AGENCY SURVEY TABLE

State WIC Agency Survey Table

1. Name of State WIC Program	2. Name and Title of Person Completing Survey	3. Phone Number to Call for Follow Up Questions

#	Question related to contracting and procurement	Yes/No
4.	Do you contract with independent local agencies? (i.e., not offices or subdivisions of the state agency)	
5.	Do you also have staff, offices or subdivisions of the state agency that conduct clinics and provide direct participant services?	
6.	Do you limit the number of local agencies you contract with?	
7.	Are your contracts with local agencies awarded through a competitive process?	
8.	For what length of time are your local agency contracts awarded? (e.g. one year, two years, etc.)	

#	Question related to reimbursement process for local agencies	Yes/No
9.	Do you use a “cost per participant” approach or formula to fund each local agency? (If not, skip to question 17)	
10.	Does each local agency get the same base amount per participant?	
11.	Do you use any other factors to adjust the amount per participant? (e.g. caseload size, geographic location, cost of living differences, special populations, etc.)	
12.	Are there any expenses that are funded in the local agency contracts but outside of the participant based approach or formula? (e.g. attendance at conferences, etc.)	
13.	Does the state agency directly purchase any supplies, materials, equipment, training, etc. that are used primarily in the local agencies? (i.e. costs that would not be reflected in local agency	



	budgets or contracts)	
14.	Do local agencies report any in-kind contributions they provide?	
15.	Are local agency contract totals adjusted at some point during the year if the agency does not serve the assigned caseload level?	
16.	Do you have any plans to change your approach in the next year (FY'2003)?	
17.	If you do not use cost per participant in your allocation of funds to local agencies, how are funds allocated?	

Mail: Burger, Carroll & Associates, Inc.

Fax: 505-982-9880

1421 Luisa Street, Suite A

Atten: MO Funding Analysis

Santa Fe, NM 87505

APPENDIX D STATE WIC AGENCY PHONE INTERVIEW FORM

Deliverable 12: Telephone Interviews - Attachment One

Date:

Time:

1. State:
2. Name and title:
3. Phone number/email address:

Questions related to contracting and procurement:

4. How many contracts do you currently have with independent local agencies? (i.e., not offices or subdivisions of the state agency)
5. Do you limit the number of local agencies you contract with? If so, how?
6. Which of the following types of agencies do you contract with?
 - a. City health department
 - b. County health department
 - c. Private, not-for-profit health agency (including FQHCs)
 - d. Hospital
 - e. Private, not-for-profit human services agency
 - f. Community Action Agency
 - g. Other (please describe)
7. Do each of your local contract agencies have discrete (not overlapping) service areas?
8. Do some of your local agencies serve multiple counties?
9. Do the majority of your local agencies operate multiple clinic sites (either full or part time)?
10. What is your competitive grant application process like?
11. If yes, is there actual competition for contracts, or is the incumbent agency typically the only agency submitting a proposal?
12. For what length of time are your local agency contracts awarded? (e.g., one year, two years, etc.)
13. Is there an automatic renewal process for existing local agencies?

Questions related to reimbursement process for local agencies:

14. When and how do you begin your annual budgeting process?
15. How do you determine how much of the NSA grant to keep at the state and how much to give to local agencies?
16. What percentage goes to local agencies, either through the formula or in total?
17. Could we get a copy of your last FNS-798 showing the division of funds between the state and local levels and the four categories of spending? (either hard copy or electronic)
18. How do you determine the base “cost per participant” to use for the formula? Is the amount adjusted each year?
19. What factors are used to adjust the amount per participant between agencies?

(Examples: Size of authorized caseload; Size or geographic location of service area; Cost of living differences between geographic areas; Salary differences between geographic areas; Type of agency; Special population served; Other)
20. Do you specify minimum required amounts for nutrition education and breastfeeding promotion that local agencies must spend? Are these included in the based amount per participant.? If not, how are these handled?
21. What local agency costs are funded in the local agency contracts but outside of the participant based approach or formula? (e.g. attendance at conferences, etc.) How did you arrive at these? Do all agencies receive them, or do they have to request them?
22. What types of supplies, materials, equipment, training, etc. that are used primarily in the local agencies are purchased directly by the State?
23. Do local agencies have any state-defined responsibilities for retailer management?
24. Do local agencies have any state-defined responsibilities for outreach?
25. Do agencies get a fixed amount in their contract based on their authorized caseload or do they have to “earn” their funding level each month based on the number of participants they serve?
26. If the amount is fixed, is the total adjusted at some point during the year if the agency does not serve the assigned caseload level? If so, when and how?
27. How long have you been using this approach (in number of years)?
28. Did you involve local agencies in developing the funding approach?
29. Are you satisfied with your approach to funding local agencies?

30. If not, what part are you not satisfied with?
31. Do you believe your local agencies are satisfied with your approach?
32. If not, what part are they not satisfied with?
33. Do you have any plans to change your approach in the next year (FY'2003)?

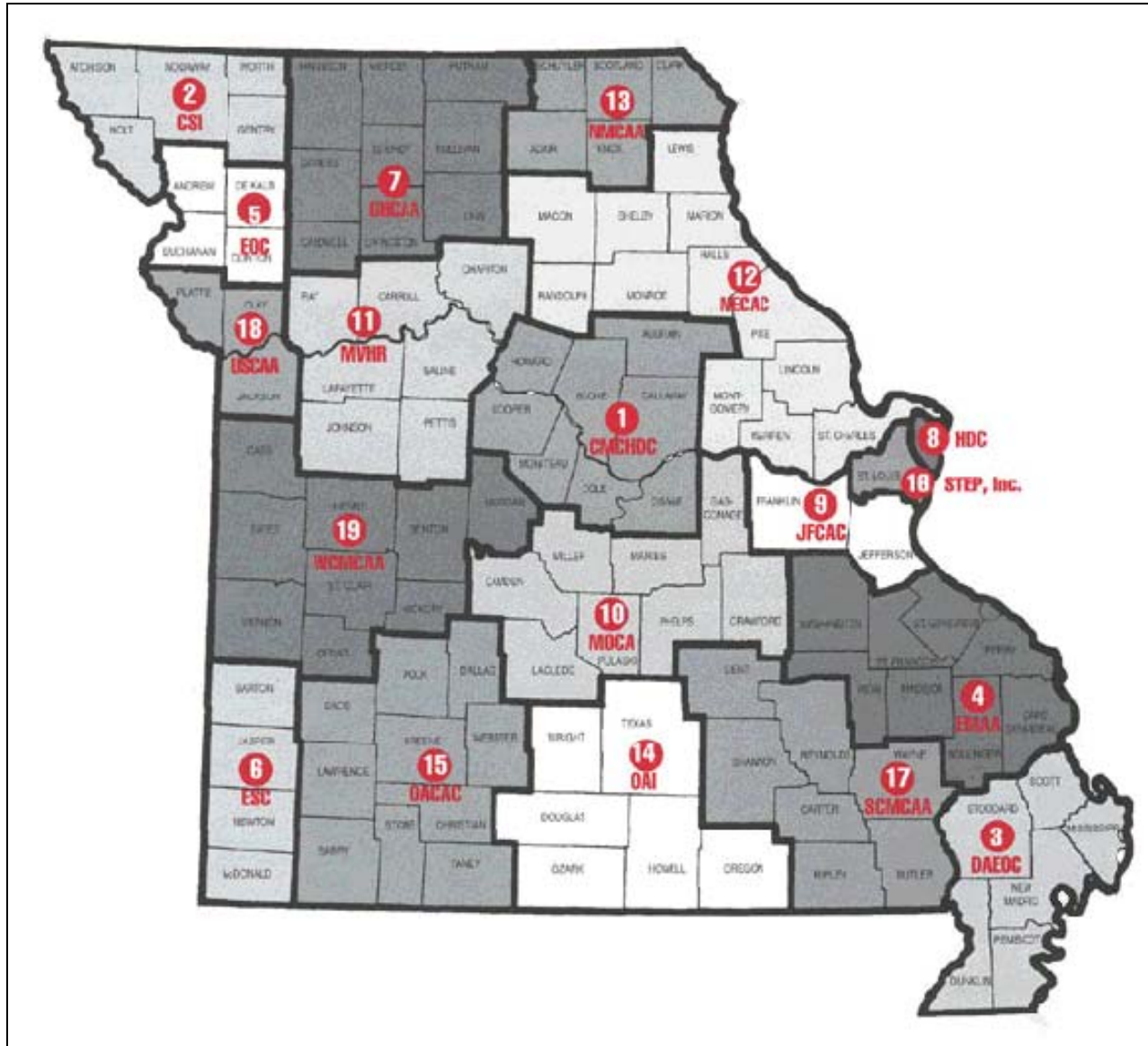
APPENDIX E DETAILED ALTERNATIVE TWO SPREADSHEETS

APPENDIX F DETAILED ALTERNATIVE THREE SPREADSHEETS

See Electronic Excel Spreadsheet

APPENDIX G-1 MISSOURI COMMUNITY ACTION PROGRAMS

Missouri Community Action Programs



* Information collected from the Missouri Association for Community Action website:
<<http://www.communityaction.org>>

MAP References

- 1 Central Missouri Counties' Human Development Corporation (CMCHDC) Columbia
Serving Counties: Audrain, Boone, Callaway, Cole, Cooper, Howard, Moniteau, Osage

- 2 Community Services, Inc. of Northwest Missouri (CSI) Maryville
Serving Counties: Atchison, Gentry, Holt, Nodaway, Worth
- 3 Delta Area Economic Opportunity Corporation (DAEOC) Portageville
Serving Counties: Dunklin, Mississippi, New Madrid, Pemiscot, Scott, Stoddard
- 4 East Missouri Action Agency (EMAA) Park Hills
Serving Counties: Bollinger, Cape Girardeau, Iron, Madison, Perry, St. Francois, Ste. Genevieve, Washington
- 5 Economic Opportunity Corporation of Greater St. Joseph (EOC) St. Louis
Serving Counties: Andrew, Buchanan, Clinton, Dekalb
- 6 Economic Security Corporation of the Southwest Area (ESC) Joplin
Serving Counties: Barton, Jasper, McDonald, Newton
- 7 Green Hills Community Action Agency (GHCAA) Trenton
Serving Counties: Caldwell, Daviess, Grundy, Harrison, Linn, Livingston, Mercer, Putnam, Sullivan, Carroll, Ray
- 8 Human Development Corporation of Metropolitan St. Louis (HDC) St. Louis
Serving Counties: City of St. Louis and Wellston
- 9 Jefferson-Franklin Community Action Corporation (JFCAC) Hillsboro
Serving Counties: Franklin, Jefferson
- 10 Missouri Ozarks Community Action, Inc. (MOCA) Richland
Serving Counties: Camden, Crawford, Gasconade, Laclede, Maries, Miller, Phelps, Pulaski
- 11 Missouri Valley Human Resource Community Action Agency (MVHR) Marshall
Serving Counties: Carroll, Chariton, Johnson, Lafayette, Pettis, Ray, Saline
- 12 North East Community Action Corporation (NECAC) Bowling Green
Serving Counties: Lewis, Lincoln, Macon, Marion, Monroe, Montgomery, Pike, Ralls, Randolph, Shelby, St. Charles, Warren
- 13 Northeast Missouri Community Action Agency (NMCAA) Kirksville
Serving Counties: Adair, Clark, Know, Scotland, Schuyler
- 14 Ozark Action, Inc. (OAI) West Plains
Serving Counties: Douglas, Howell, Oregon, Ozark, Texas, Wright

15 Ozarks Area Community Action Corporation (OACAC) Springfield

Serving Counties: Barry, Christian, Dade, Dallas, Greene, Lawrence, Polk, Stone, Taney, Webster

16 Services Toward Empowering People, Inc. (STEP) St. Louis

Serving Counties: St. Louis County

17 South Central Missouri Community Action Agency (SCMCAA) Winona

Serving Counties: Butler, Carter, Dent, Reynolds, Ripley, Shannon, Wayne

18 United Services Community Action Agency (USCAA) Kansas City

Serving Counties: Clay, Jackson, Platte

19 West Central Missouri Community Action Agency (WCMCAA) Appleton City

Serving Counties: Bates, Benton, Cass, Cedar, Henry, Hickory, Morgan, St. Clair, Vernon

**APPENDIX G-2
MISSOURI COMMUNITY HEALTH CENTERS
(FEDERALLY QUALIFIED HEALTH CENTERS)**

A map of Missouri divided into its counties. Red stars indicate the locations of Community Health Centers, and green dots indicate the locations of Satellite Clinics. The legend at the bottom shows a red star next to the text "=Community Health Center" and a green dot next to the text "=Satellite Clinic".

Legend:

- ★ =Community Health Center
- =Satellite Clinic

Burger, Carroll & Associates, Inc.

Community Health Center	Area Served
Family Care Health Centers	St. Louis (3 locations)
Grace Hill Neighborhood Health Centers	St. Louis (6 locations)
Myrtle H. Davis Comprehensive Health Center	St. Louis (2 locations)
People's Health Centers	St. Louis (5 locations)
Cabot Westside Clinic	Kansas City
Samuel U. Rodgers Community Health Center	Lexington Kansas City (8 locations) Platte City Riverside
Swope Parkway Health Center	Kansas City - MO (6 locations) Kansas City - KS (2 locations)
Big Springs Medical Association	Annapolis Ellington Emminence Van Buran
Central Ozarks Medical Center	Richland
Cross Trails Medical Center	Advance Cape Girardeau Marble Hill
Douglas County Public Health Services Group, Inc.	Ava Gainsville
Family Health Center	Columbia (2 locations)
Northeast Missouri Health Council	Kirksville (4 locations) Edina Memphis
Northwest Health Services	Braymer Hamilton King City Mound City Oregon St. Joseph (2 locations) Wathena, Kansas
Ozark Tri-County Health Care Consortium	Anderson Cassville Neosho
Southeast Missouri Health Network	Bernie Kennett Lilbourn New Madrid Portageville Sikeston

SPECIFIC LOCATIONS BY COMMUNITY HEALTH CENTER

Family Care Health Centers		
Clinic Name	Address	City
Family Care Health Centers		St. Louis
Family Care Health Center-Carondelet	6313 Michigan Ave	St. Louis
Family Care Health Center-Forest Park Southeast	4352 Manchester Ave	St. Louis
Dental	422 Wilmington	St. Louis

Grace Hill Neighborhood Health Centers, Inc		
Clinic Name	Address	City
Grace Hill Neighborhood Health Centers, Inc	2600 Hadley Street	St. Louis
Cochran	1206 N. 9th	St. Louis
Soulard	2028 S. 12th Street	St. Louis
South-Center de Salud Sur	3400 S. Jefferson Ave	St. Louis
St. Stephen's	Park & S. 14th Street	St. Louis
Water Tower	4308 N. Grand	St. Louis

Myrtle H. Davis Comprehensive Health Centers, Inc		
Clinic Name	Address	City
Myrtle H. Davis Comprehensive Health Center, Inc.	5471 Dr. Martin Luther King Drive	St. Louis
Myrtle H. Davis Comprehensive Health Center, Inc.	4411 N. Newstead Ave	St. Louis

People's Health Center		
Clinic Name	Address	City
People's Health Centers, Inc.	5701 Delmar Blvd	St. Louis
People's Health Centers, Inc.	7200 Manchester	Maplewood
Blossom House	5331 Enright	St. Louis
Meda P. Washington Continuing Edu. Ctr	2330 Vandeventer	St. Louis
People's Health Centers, Inc.	North County	

Additional People's Health Center Locations:

- **Mobile Van Health Services**
 - Deer Creek Health Care
 - Meda P. Washington Educational Center
 - St. Louis Public Schools
 - Fanning Middle School
 - Williams Middle School
 - Stowe Middle School
 - Blewett Middle School
 - L'Overture Middle School
- **Wellston School District**
 - Wellston Early Childhood Center
 - Central Elementary
 - Curtis Bishop Middle School
- **Maplewood-Richmond Heights School District**
 - AB Green Middle School
 - Bruce Elementary School
 - Chaney School
 - Early Childhood Center
 - Maplewood-Richmond Heights Senior High School

Cabot Westside Clinic		
Clinic Name	Address	City
Cabot Westside Clinic	1810 Summit Street	Kansas City

Samuel Rodgers Community Health Center		
Clinic Name	Address	City
Samuel U. Rodgers Community Health Center	825 Euclid Avenue	Kansas City
Rodgers Health Center-South		Kansas City
Samuel U. Rodgers Adult Day Care	3325 Prospect	Kansas City
Quality Care Health Center	Northeast High School	Kansas City
Panda Place Wellness Center	McCoy Elementary School	Kansas City
William J. Herron Health Center	Southeast High School	Kansas City

Samuel Rodgers Community Health Center		
Clinic Name	Address	City
Pegasus Health Center	Woodland-Edison School	Kansas City
Rodgers Lafayette Community Health Center		Lexington
Platte County Health Department		Riverside
Platte County Health Department		Platte City
Kansas City Free Health Clinic	39th Main Street	Kansas City

Swope Parkway Health Center		
Clinic Name	Address	City
Swope Parkway Health Center	3801 Blue Parkway	Kansas City
Imani House		Kansas City
Curtis Franklin Lodge		Kansas City
Kanzetta Harris House		Kansas City
Northland Health Clinic		Kansas City
Douglas Community Health Center		Kansas City
Birchtree Annex		Kansas City
Brown Avenue Clinic		Kansas City

Big Springs Medical Association		
Clinic Name	Address	City
Big Springs Medical Association, Inc.	Highway 106 & 2nd Street	Ellington
Big Springs Medical Clinic	402 Main St	Van Buren
Ellington Family Clinic	Highway 106 & 2nd Street	Ellington
Shannon County Family Clinic	209 Main Street	Eminence
Annapolis Family Clinic	Highway 49 South	Annapolis

Additional facilities located in Ellington, Eminence, Salem, Van Buren, and St. James

Central Ozarks Medical Center		
Clinic Name	Address	City
Central Ozarks Medical Center	P.O. Box 777	Richland

Cross Trails Medical Center		
Clinic Name	Address	City
Cross Trails Medical Center	937 Broadway, Suite 202	Cape Girardeau
Cross Trails Medical Center		Advance
Cross Trails Medical Center		Marble Hill

Douglas County Public Health Services Group, Inc	
Clinic Name	City
Douglas County Public Health Services Group, Inc	Ava
Douglas County Public Health Services Group, Inc	Gainesville

Family Health Center		
Clinic Name	Address	City
Family Health Center of Boone County	1500 Vandiver, Suite 110	Columbia
J.W. "Blind" Boone Community Center	Providence Road	Columbia

Northeast Missouri Health Council		
Clinic Name	Address	City
Northeast Missouri Health Council	800 West Jefferson	Kirksville
NEMO Family Practice		Kirksville
NEMO Women/FP		Kirksville
NEMO Veterans Clinic		Kirksville
NEMO Dental Clinic		Kirksville
NEMO Pediatric/WIC		Kirksville
NEMO FP		Edina
NEMO FP		Memphis

Additional facilities located in Kirksville, Memphis, and Edina

Northwest Health Services		
Clinic Name	Address	City
Northwest Health Services, Inc.	2303 Village Drive	St. Joseph
Northwest Health Services, Inc.	305 Rhode Island	King City
Northwest Health Services, Inc. (Annex)	514 State Street	Mound City
Northwest Health Services, Inc.	502 State Street	Mound City
Northwest Health Services, Inc.	401 East Nodaway	Oregon
Hamilton Medical Clinic	One Cross Street	Hamilton
Braymer Clinic	109 Main	Braymer
Wathena Medical Center	324 St. Joseph Street	Wathena
Family Health Center	904 S. 10th Street	St. Joseph
Family Medicine Associates	2303 Village Drive	St. Joseph

Additional facilities located in Mound City, St. Joseph, King City, Oregon, Braymer, and Hamilton

Ozark Tri-County Healthcare Consortium		
Clinic Name	Address	City
Ozark Tri-County Health Center	104 Main Street	Anderson
Ozark Tri-County Health Clinic-Barry County		Cassville
Ozark Tri-County Health Clinic-Newton County		Neosho

Southeast Missouri Health Network		
Clinic Name	Address	City
Southeast Missouri Health Network	401 Main Street	New Madrid
New Madrid Family Clinic	409 Mott Street	New Madrid
Sikeston Family Clinic	903 S. Kingshighway	Sikeston
Libourn Family Clinic	211 N. Third	Lilbourn
Portageville Family Clinic	314B E. Main	Portageville
Kennett Migrant/ Family Clinic	807 S. By-Pass	Kennett
Bootheel Dental Clinic	409 Mott Street	New Madrid
Kennett Dental Clinic	807 S. By-Pass	Kennett
Bernie Family Clinic	200 W. Hunts Road	Bernie

Additional facilities located in Kennett, Lilbourn, and Portageville